AlwaysCare℠
AlwaysDental℠ AlwaysVision℠
A Starmount Life Insurance Company

East Feliciana Parish School

CONTINUATION OF COVERAGE FOR RETIREES

This is to request that the following retired employee wishes to continue their Dental or Vision coverage with Starmount:

Name: Member#

Date of retirement:
Effective date of coverage:

Below are the payment methods available on the retiree policy. Please indicate which method is preferred, and mail all documentation, along with your remittance to:

Starmount Life Co.
PO BOX 98100
Baton Rouge, LA 70898-9100

_____I elect to have my premium drafted from my checking account every month. **Please complete the attached Automatic Bank Draft Authorization Form.**

_____I elect to mail in the premium due every month.

___/____/____ _____
Date Signed Signature of Eligible Retiree

*******No addition will be allowed on this policy, unless there is a qualifying life status change (i.e.: marriage) *******

I elect to continue the following coverage:

VISION		**DENTAL**	
____EE	$ 8.56	____EE	$ 32.86
____ES	$17.10	____ES	$ 65.68
____EC	$18.18	____EC	$ 72.26
____EF	$28.50	____EF	$105.00

This continuation form, along with up-to-date premium must be received at Starmount within 60 days of the date of retirement, to qualify for continuing insurance.

✆ **1-888-729-5433 (In Baton Rouge: 926-2888)**

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Automatic Bank Draft Authorization Form

Group Name: **East Feliciana Parish School**

Group Code: **EFPSB713**

Client Name_____ Date_____/_____/_____

Phone Number _(_____)_____ SS# _____

Payment Method

_____ Checking Routing No. _____

Checking Account No. _____

I authorize Starmount to deduct future premium payments from my personal checking account automatically. ***Please attach a voided check to this form.**

_____ _____/_____/_____
Signature Date

Starmount Life Insurance Company
P.O. Box 98100 • Baton Rouge, LA 70898-9100
✆ 1-888-729-5433 Ext. 2013 (In Baton Rouge: 926-2888)