



**Starmount Life Insurance Company**

P. O. Drawer 98100  
Baton Rouge, LA 70898-9100

**Protection Change/Reinstatement Request**

**I request that Starmount Life Insurance Company for Policy # \_\_\_\_\_:**

Change my protection from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ In the future, deduct payment from my checking account. (A cancelled check is enclosed)  
Change my policy type to \_\_\_\_\_ I will pay: \_\_\_\_\_ Annually; \_\_\_\_\_ Every 6 months; \_\_\_\_\_ Every 3 months; \_\_\_\_\_ Monthly  
Reinstate policy # \_\_\_\_\_ (We recommend every three months.)  
Other changes: \_\_\_\_\_

( ) ( )  
↑ Last Name First ↑ Middle ↑ ↑ Home Phone ↑ Work Phone / /  
↑ Street Address ↑ City ↑ State ↑ Zip ↑ Date of Birth ( )  
↑ Height & Weight ↑ Doctor's Name Address ↑ ↑ Phone

- A. Have you had, scheduled or been advised to have any medical or surgical examination or current treatment for any disorder, injury or sickness during the past 5 years, or do you now have any impairment, disorder or disease? Have any self-administered tests not been normal? Do you have any medical conditions for which you have not consulted a doctor? (If yes, please explain.) \_\_\_\_\_ Yes  No
- B. Have you ever: had high blood pressure; cancer; a tumor; polyps; diabetes; asthma; an ulcer; a stroke; a significant weight loss; epilepsy; any disease or disorder of the kidneys, heart, blood, lungs, liver (in the last 10 years for Indiana); tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection; had mental disease, depression or emotional disorder, alcoholism, a drug habit or taken illegal drugs; been ticketed for DWI or DUI or had a felony conviction? (If yes, circle applicable ones and explain.) \_\_\_\_\_ Yes  No
- C. Names of doctors seen in the last 3 years (full name): \_\_\_\_\_  
Doctors locations (city/state) \_\_\_\_\_
- D. Why did you see these doctors? \_\_\_\_\_
- E. What medications are you currently taking? \_\_\_\_\_  
For what condition(s)? \_\_\_\_\_
- F. Do you expect to be hospitalized in the next 12 months? If yes, why? \_\_\_\_\_ Yes  No
- G. Have you had an application for life or health insurance rated, postponed, withdrawn or modified? (If yes, circle applicable ones.) Yes  No
- H. Have you smoked, chewed or used tobacco in the last 12 months? Yes  No   
If you smoke cigarettes, do you smoke over 2 packs per day? Yes  No
- I. Are you employed? Yes  No  What is your occupation/source of income? \_\_\_\_\_

I have read the above questions and declare the answers are complete and true. I agree the answers will form a part of the policy and the insurance shall not be in force (in Kansas, the insurance in force shall be limited to \$1,000) until this application or reinstatement has been approved by the company, the policy reinstated or the protection increased and written notice from Starmount is delivered to me when I am in the same health condition as described above, subject to all the conditions set forth in the policy and the next premium paid by me. I affirm that there has been no change in my health since my original application for life insurance with Starmount was sent. I understand that this reinstatement or increase in protection, if granted, is subject to a new two-year contestability of my policy. Suicide or material misrepresentation may result in the cancellation of the reinstated policy or the increased coverage or denial of a claim based on events occurring during the two years following reinstatement or increase in protection.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau or other organization or person that has any records of me, my health, or any member of my family to give STARMOUNT LIFE any such information. This includes knowledge about drug abuse, alcoholism, mental illness, and H.I.V. and/or A.I.D.S. status. Although information about drug abuse, alcoholism, mental illness, and H.I.V. and/or A.I.D.S. status may be protected by government regulation, I allow Starmount to collect it to determine insurability. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree (See back of page for state specific fraud language). This authorization expires in 30 months, but can be revoked at any time with the applicant's written notification. A copy is as valid as the original. I am also aware that these records may be subject to re-disclosure by the recipient.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Agent # \_\_\_\_\_  
**Your Signature** Date

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty (in Ohio, is guilty of insurance fraud), (in Georgia and Texas, may be guilty of a felony), (in Arkansas, and Louisiana, is guilty of a crime and may be subject to fines a confinement in prison) of a felony of the third degree. In New Mexico, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**