



Employer Acknowledgement of Enrollment into StarStone Medical Provider Network (MPN)

I acknowledge that our company is/or will be using StarStone National Insurance Company's MPN for our employees.

We will place employees signature verification forms in their personnel file.

Please provide the date you initially advised your existing employees of the StarStone MPN: _____ then forward this form to andrea.perrigoue@enstargroup.com.

Employer Name

Policy Number

Employer Representative Name (please print)

Title

Employer Representative Signature

Today's Date

**Administrator: please sign and return to andrea.perrigoue@enstargroup.com
and cc George@ShomerInsurance.com**