Renaissance®

DENTAL · VISION · LIFE · DISABILITY

Renaissance Life & Health
Insurance Company of America
P.O. Box 1596, Indianapolis, IN 46206

RENAISSANCE EMPLOYEE ENROLLMENT FORM

—Please Type Or Print Clearly In Dark Ink—

SECTION I | EMPLOYER INFORMATION (Policyholder Use Only)

Name of Employer:		**Group ID Number:**	**Billing Class:**
Unit Name and Number:		**Policy Number(s):**	
Date of Hire or Rehire:	**Hours Worked Per Week:**	**Earnings: $** _____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other If Other Specify: _____	

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Re-enrollment ☐ Change in Status ☐ Other
If Other Specify: _____

SECTION II | EMPLOYEE INFORMATION (Completed By Applicant)

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	**Email:** **Phone:**	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Social Security Number:	**Date of Birth** *(mm/dd/yyyy)*:	**Job Title/Occupation:**	

SECTION II.A | SPOUSE INFORMATION (If Applying For Benefits For Your Spouse*, Complete Information Below)

Your ☐ Spouse ***OR*** ☐ Domestic Partner* *(Check One Box Only)*	**Full Name** *(Last, First, MI)*:	☐ Male ☐ Female	**Date of Birth** *(mm/dd/yyyy)*:	**Social Security Number:**
Street Address *(Include Apt#/Suite)*: ☐ ***Check if same as above***		**City:**	**State:**	**ZIP Code:**

SECTION II.B | CHILD(REN) INFORMATION (If Applying For Benefits For Your Dependent Child(Ren), Complete Information Below)

Dependent's Name (Last, First, MI)	Male (M) Female (F)	Full-Time Student	Date of Birth (mm/dd/yyyy)	Social Security Number
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		

If more than three children are to be enrolled, include a separate list including the above information with this form

**This Employee Enrollment Form uses the term "Spouse" to refer to the person, either Spouse or Domestic Partner, for whom you are applying for benefits. If your Employer does not extend benefits to Domestic Partners and you are not enrolling a Spouse, leave this section blank.*

SECTION III | COVERAGE ELECTIONS

IF YOU SELECT "NO COVERAGE" BELOW, YOU ACKNOWLEDGE THAT YOU UNDERSTAND THAT IF YOU APPLY FOR COVERAGE AT A LATER DATE, YOU WILL BE CONSIDERED A LATE APPLICANT, YOU MAY BE SUBJECT TO WAITING PERIODS AND/OR REQUIRED TO FURNISH EVIDENCE OF INSURABILITY AT YOUR OWN EXPENSE, AND THAT RENAISSANCE WILL HAVE THE RIGHT TO REFUSE YOUR REQUEST.

A. DENTAL COVERAGE	**Plan Option** *(if choice provided)*:	**Select One:** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ No Coverage
B. VISION COVERAGE	**Plan Option** *(if choice provided)*:	**Select One:** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ No Coverage

If applying for Life or Disability insurance, please check with your Human Resources Department on coverage options and health information requirements.

C. TERM LIFE INSURANCE	**EMPLOYEE**	☐ Basic Life ☐ Basic Accidental Death & Dismemberment (AD&D) ☐ No Coverage ☐ Supplemental Life: Amount Electing: $ _____ OR _____x Base Annual Compensation ☐ Supplemental AD&D: Amount Electing: $ _____ OR _____x Base Annual Compensation	
	SPOUSE	☐ Supplemental Life Amount Electing: $ _____	☐ Supplemental AD&D Amount Electing: $ _____
	CHILD	☐ Supplemental Life Amount Electing: $ _____	☐ Supplemental AD&D Amount Electing: $ _____
D. SHORT TERM DISABILITY (STD) INSURANCE	**EMPLOYEE ONLY**	☐ STD ☐ No Coverage ☐ Voluntary STD: Flat Amount Per Week: $_____ ☐ Voluntary STD: % of Weekly Earnings: _____%	
E. LONG TERM DISABILITY (LTD) INSURANCE	**EMPLOYEE ONLY**	☐ LTD ☐ No Coverage ☐ Voluntary LTD: Flat Amount Per Week: $_____ ☐ Voluntary LTD: % of Weekly Earnings: _____%	

	BENEFITS INCLUDED	PLAN LEVEL	SELECT ONE
PACKAGE BENEFITS	Dental+ Vision +Life+LTD+STD	☐ 1 ☐ 2 ☐ 3	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ None
FLEX PLAN BENEFITS	Dental+ Vision +Life+LTD+STD		☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ None

SECTION IV | BENEFICIARY (Completed Only If Life/AD&D Coverages Are Elected)

Full Name (First, Last, MI)	Relationship To You	Social Security Number	Percentage
			0.00%
			0.00%
			0.00%
			0.00%

If you need more room, please request our Beneficiary form

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

SECTION V | ELECTRONIC DELIVERY OF DOCUMENTS

Electronic Delivery of Policy Document

☐ Yes, send the following information electronically: Certificate of Coverage, Summary of Benefits, ID Cards, Explanation of Benefits, Renewal Letters and related coverage and claim documents.

By checking the box above, you are agreeing to receive such materials electronically pursuant to the Terms for Paperless Delivery attached to this Employee Enrollment Form. **You must provide a current email address on the first page of this Employee Enrollment Form.** If the box is not checked, all materials will be sent by hard copy.

SECTION VI | SIGNATURES

My signature on this Employee Enrollment Form further represents that:

I authorize my Employer's Payroll Department to deduct the required premium, if any, from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my Employer and Renaissance, and are to be paid to Renaissance when due.

I am applying for the coverages designated for which I am eligible under my Employer's plan with Renaissance and I understand that my dependents are not eligible for coverage if I am not enrolled. No coverages above the Guaranteed Issue Limit are effective until my completed Evidence of Insurability is approved by Renaissance. If I am applying as a Late Applicant, I understand that no coverage is effective until my completed Evidence of Insurability is approved by Renaissance and certain limitations and waiting periods may apply.

I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work.I also understand that dependent coverage will not become effective while the dependent is confined to the Hospital or otherwise unable to perform the duties of a person of like sex and age.

For any Life or AD&D coverage for which I am applying, I designate the beneficiary(ies) named in the beneficiary section of this Employee Enrollment Form to receive any benefits payable in the event of my death.

The Employee Enrollment Form is subject to approval, refusal or modification in accordance with Renaissance guidelines. Misrepresentation or fraud will cause this form and subsequent coverage to be null and void from the start. WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

FOR DENTAL AND VISION ENROLLEES, THE FOLLOWING FRAUD NOTICE APPLIES TO THOSE COVERAGES: WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD. *(Please see the following page for state-specific variations of this fraud notice.)*

Applicant Signature *(Required)*: _____ Date: _____

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FRAUD WARNING NOTICES: If you reside in a state where one of these fraud notices applies, please review your state-specific fraud notice.

AK: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL/AR/LA/NM/RI/WV: 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 fines and confinement in prison.

CA: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

GA: A natural person convicted of a violation of insurance fraud shall be guilty of a felony and shall be punished by imprisonment for not less than two or more than ten years, or by a fine of not more than ten thousand dollars, or both.

HI: Any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

KS: 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 material fact thereto, may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

ME/TN/WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefit.

MD: Any person who knowingly **or** willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly **or** willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NC: Any person who, with intent to injure, defraud or deceive an insurer or an insurance claimant, submits an application or files a claim containing a false or deceptive statement is guilty of a crime (Class H felony) which MAY subject the person to criminal and civil penalties.

NH: 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 shall also be subject to a civil penalty.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OH/OR: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: 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.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

VA: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.