Renaissance℠
Dental & Vision

Eligibility Enrollment/Update

☐ **Dental** ☐ **Vision**

Social Security Number _____

Group Name _____ Group/Subgroup# _____

Plan Enrollment/Update Information (please indicate type of update and fill in appropriate information)

Type of Update: New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination of Benefits ☐

Group Transfer From: Group/Subgroup#	To: Group/Subgroup#	Rate Code Change From:	To:	Effective Date of Change	Change is for:
					Certificate Holder ☐ Dependent ☐

Certificate Holder Information (please complete for all enrollments/updates)

First Name _____ MI _____ Last Name _____

Street Address _____ Check if New Address ☐

City _____ State _____ ZIP Code _____ E-mail address _____

Status: Active ☐ COBRA ☐ Retiree ☐ Surviving ☐ Job Title _____

Birth Date _____ (MM/DD/YYYY) Date of Hire _____ (MM/DD/YYYY) Coverage Effective Date _____ (MM/DD/YYYY)

Enrollment/Corrections to Information (please fill in for spouse/dependents for first-time enrollment or corrections)

SPOUSE
First Name _____ MI _____ Last Name, if different _____

Birth Date _____ (MM/DD/YYYY) SSN _____ Status: Legal ☐ Surviving ☐ Dental ☐ Vision ☐

DEPENDENT #1
First Name _____ MI _____ Last Name, if different _____

Birth Date _____ (MM/DD/YYYY) SSN _____ Status: IRS ☐ Surviving ☐ Dental ☐ Vision ☐

DEPENDENT #2
First Name _____ MI _____ Last Name, if different _____

Birth Date _____ (MM/DD/YYYY) SSN _____ Status: IRS ☐ Surviving ☐ Dental ☐ Vision ☐

DEPENDENT #3
First Name _____ MI _____ Last Name, if different _____

Birth Date _____ (MM/DD/YYYY) SSN _____ Status: IRS ☐ Surviving ☐ Dental ☐ Vision ☐

DEPENDENT #3
First Name _____ MI _____ Last Name, if different _____

Birth Date _____ (MM/DD/YYYY) SSN _____ Status: IRS ☐ Surviving ☐ Dental ☐ Vision ☐

Employee Name _____ Employee ID _____

I request coverage under my employer's group insurance plan and authorize my employer to make deductions from my earnings of the required contributions, if any, toward the cost of the coverage. I will be provided a certificate of coverage in either electronic or paper form. The electronic delivery of my certificate of coverage must be pursuant to the Terms for Paperless Delivery (attached to this form). Such terms provide the manner in which I can request a paper copy at any time.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature _____ Date _____