Renaissance

DENTAL • VISION • LIFE • DISABILITY

P.O. Box 1596 Indianapolis, IN 46206

# Dental and Vision Eligibility *Enrollment/Change/Waive*

☐ **Dental** Dental Plan Selection *(if applicable)*: _____ ☐ **Vision**

**Type of Update**—*please indicate type of update and fill in appropriate information*

☐ Waive Benefits ☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination of Benefits

**if you are waiving your benefits please see page two**

Effective Date of Change *(if applicable)*: _____ Change is for: ☐ Subscriber ☐ Dependent

## Employer Information

Group Name: _____ Subgroup Name *(if applicable)*: _____

Group Number: _____ Subgroup Number *(if applicable)*: _____

## Subscriber Information—*please complete for all enrollments/changes*

☐ Check if New Address

Status: ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving

Full Name: _____ Social Security Number: _____
First M.I Last

Street Address: _____ Suite/Apartment: _____

City: _____ State: _____ ZIP Code: _____

E-mail Address: _____

Company Name: _____ Job Title: _____

Birth Date: ____/____/____ Date of Hire: ____/____/____ Coverage Effective Date: ____/____/____
MM / DD / YYYY MM / DD / YYYY MM / DD / YYYY

## Spouse/Dependent Information—*please fill in spouse/dependent information for first-time enrollment or corrections)*

| Print Full Legal Name *(first, MI, last)* | Relationship | Dental | | Vision | | Birthdate *(mm/dd/yyyy)* | Status *(if applicable)* |
|---|---|---|---|---|---|---|---|
| | | add | drop | add | drop | | |
| | SPOUSE | ☐ | ☐ | ☐ | ☐ | | ☐ Surviving |
| | DEPENDENT ONE | ☐ | ☐ | ☐ | ☐ | | ☐ Surviving ☐ Disabled ☐ Legal |
| | DEPENDENT TWO | ☐ | ☐ | ☐ | ☐ | | ☐ Surviving ☐ Disabled ☐ Legal |
| | DEPENDENT THREE | ☐ | ☐ | ☐ | ☐ | | ☐ Surviving ☐ Disabled ☐ Legal |
| | DEPENDENT FOUR | ☐ | ☐ | ☐ | ☐ | | ☐ Surviving ☐ Disabled ☐ Legal |

**THIS POLICY PROVIDES DENTAL/VISION BENEFITS ONLY. REVIEW YOUR POLICY CAREFULLY.**

Printed Subscriber Name: _____

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 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 not to exceed five thousand dollars and the stated value of the claim for each such violation.**
*(Please see state-specific variations of this fraud notice)*

Subscriber Signature: _____ Date: _____

**WAIVE COVERAGE—***if you are waiving coverage, complete this section. (waiver may not be allowed for this plan, check with your employer)*

Waive Coverage for *(check all that apply)*: ☐ Myself ☐ Spouse ☐ Child(ren) Only

I hereby certify that I understand that I am eligible for the dental program administered by Renaissance Life and Health Insurance Company of America. I decline to participate in this program.

Printed Name: _____ Signature: _____

Name of Employer: _____ Date: _____

IF RENAISSANCE LIFE AND HEALTH COVERAGE IS WAIVED BECAUSE OF COVERAGE THROUGH ANOTHER SOURCE:

Name of Other Dental Carrier: _____

Subscriber's Name: _____ Subscriber's SSN: _____

## HELPFUL TIPS—*If you have any question completing this form, the Human Resources or Personnel Department can assist you.*

**SUBSCRIBER INFORMATION—***this section should be completed in order to manage your enrollment or update your information. All this information should apply to you, the holder. Please write clearly or type.*

**Status Definitions**—*please select only **one** status:*

- **Active**—*current/active subscriber*
- **Retiree**—*retired and your group is providing benefits*
- **COBRA**—*no longer an active subscriber, but you have a self-paid continuous coverage with COBRA. (requires that many employers offer the self-paid extended coverage to certain employees/ beneficiaries that qualify and lose their health care benefits coverage. Confirm with the Human Resources /Personnel Department.)*
- **Surviving**—*surviving spouse/child of a deceased subscriber.*

**TYPE OF UPDATE**—*please select all that apply*

- **Waive—***waiving benefits for you/dependents.*
- **New Enrollment—***first time enrolling yourself or your family.*
- **Reinstatement—***reinstate coverage for yourself or dependents*
- **Change/Correction To Information—***submitting any change to information/benefits for yourself or dependents*
- **Termination of Benefits—***terminate coverage for yourself or a family member.*

**SPOUSE/DEPENDENT INFORMATION**—*this section should be completed when: registering spouse/dependents or making changes/corrections and changing information that was previously submitted to Renaissance. Please include name and last name and the type of coverage for any individual who you are enrolling or making a change or amendment for.*

**Definitions of Dependents Status**—*please select all that apply*

- **Surviving—***spouse or child of a deceased subscriber.*
- **Legal—** *an individual whom the subscriber has legal guardianship or a similar arrangement that confers authority (and the corresponding duty) to care for the person and property of the individual under applicable law.*
- **Disabled—***a legal dependent who is permanently disabled before the date their coverage would otherwise end because of age. Dependent must be eligible to be claimed as an exemption, within the meaning of the U.S. Internal Revenue Code*

**FRAUD WARNING NOTICES:** If you reside in a state that fraud notices apply, 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.

**AZ :** Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes an such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

**CA:** 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.

**DE/ID/IN:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**FL:** 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.

**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.

**NE/NY:** 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 not to exceed five thousand dollars for the first violation, ten thousand dollars for the second violation, and fifteen thousand dollars for each subsequent violation and the stated value of the claim for each such violation.

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

**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 is guilty of insurance fraud.

**OK:** 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.

Renaissance®

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Underwritten by Renaissance Life & Health Insurance Company of America, Indianapolis, IN, and in New York by Renaissance Health Insurance Company of New York, NY. Both companies may be reached at PO Box 1596, Indianapolis, IN 46206. In certain states, vision coverage may be underwritten by Vision Service Plan Insurance Company or VSP Vision Care, Inc. Both companies can be reached at 3333 Quality Drive, Rancho Cordova, CA 95670.