Renaissance®

DENTAL · VISION · LIFE · DISABILITY

Renaissance Life & Health
Insurance Company of New York
2 Court St. Suite 102, Binghamton, NY 13901
NEW YORK

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 ☐ Voluntary Life: Amount Electing: $_____ OR _____x Base Annual Compensation ☐ Voluntary AD&D: Amount Electing: $ _____ OR _____x Base Annual Compensation	
	SPOUSE	☐ Voluntary Life Amount Electing: $ _____	☐ Voluntary AD&D Amount Electing: $ _____
	CHILD	☐ Voluntary Life Amount Electing: $ _____	☐ Voluntary 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: _____%	

SECTION IV | BENEFICIARY (Completed Only if Life/AD&D Coverages are Elected)

Full Name (First, Last, MI)	Mailing Address	Telephone Number	Relationship To You	Social Security Number	Percent

If you need more room, please request our Beneficiary form

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 WILL CAUSE THIS FORM AND SUBSEQUENT COVERAGE TO BE CONTESTED SUBJECT TO THE INCONTESTABILITY CLAUSE OF THE POLICY.

RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS AND MAY BE TAXABLE.

FRAUD WARNING (EXCLUDING LIFE INSURANCE)**: 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.**

Employee's Date of Birth (MM/YYYY): _____

Applicant Signature (Required): _____ Date: _____

Spouse's Signature (If applying for coverage): _____ Date: _____

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