Renaissance

DENTAL • VISION • LIFE • DISABILITY

P.O. Box 1596 Indianapolis, IN 46206

Application and Agreement

Please take a moment to complete this form. We will consider it along with your group's experience, enrollment data and any other applicable information, as your application to Renaissance Life & Health Insurance Company of America.

- Coverage or administration for your group will not start until you receive approval in writing from Renaissance.
- Absence of written approval does not imply acceptance.
- There may be minimum enrollment requirements.
- Rates are subject to change based on final enrollment data and any program design changes.

If you have any questions regarding this application please feel free to contact your Renaissance representative.

(Shaded titles are for Renaissance use only) **Group Number:** _____

Group Name: _____

Requested Effective Date: _____ **Renewal Date:** _____

Amount paid by Employer for: **Employee Coverage:** _____ **Dependent Coverage:** _____

Definition of Subscriber: *(for example: "All full-time employees working at least 25 hours per week.")* _____

_____

Can employees opt out of dental/vision plan? ☐ Yes ☐ No **Is there a Section 125 Plan in place?** ☐ Yes ☐ No

Is this a Management carve-out? ■ Yes ☐ No **OR** **Are any Categories of Service excluded?** ☐ Yes ☐ No

If yes, explain: _____ **Minimum Participation Requirement (%) :** _____

Number of Eligible Employees: _____ **Number of Employees Enrolling:** _____

New Employee Waiting Period: (check one) ***Waived at initial enrollment?*** ☐ Yes ☐ No

☐ First of the month following ___days **OR** ☐ First day following ___ days **OR** ☐ Date of Hire

Tax Identification Number: _____

Group Address: _____

City: _____ **County:** _____ **Telephone (** **)** _____

State: _____ **Zip Code:** _____ **Fax Number (** **)** _____

Billing Address *(if different from above)*

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Group Officer: ☐ **Mr.** ☐ **Ms.** ☐ **Dr.** _____ **Title:** _____

E-Mail Address: _____

Group Contact: ☐ **Mr.** ☐ **Ms.** ☐ **Dr.** _____ **Title:** _____

E-Mail Address: _____

Type of Industry: _____ **NAICS Code:** _____ **SIC Code:** _____ **OCC Code:** _____

Previous Carrier: ☐ None ☐ Yes **Indicate carrier:** _____

Enrollment by: ☐ Form ☐ Electronic Media **Specify:** _____

Delivery method for the Group Policy, Individual Subscriber Certificate and Summary: ☐ Electronic ☐ Paper

By checking the electronic box, you are agreeing to receive such materials electronically pursuant to the Terms for Paperless Delivery attached to this application form. If none selected, all materials will be sent by hard copy.

If paper method is selected, send materials to: _____

Enrollee ID Cards sent to: ☐ Group ☐ Member Home

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DENTAL BENEFITS:

Benefit Plan Type: ☐ Indemnity ☐ Preferred Provider (PPO) ☐ Check here if proposal is attached

Annual Open Enrollment: ☐ Policy anniversary date ☐ Other_____

Covered Services	Deductible Applies	Benefit Waiting Period (months)	Indemnity Fee For Service	Preferred Provider (PPO)	
*Please attach copy of proposal				In-Network/PPO	Out-of-Network/Non-PPO
Diagnostic & Preventive	☐	____	____%	____%	____%
Emergency Palliative	☐	____	____%	____%	____%
Fluoride	☐	____	____%	____%	____%
Prophylaxis (cleanings)	☐	____	____%	____%	____%
Space Maintainers	☐	____	____%	____%	____%
Bitewing X-rays	☐	____	____%	____%	____%
Full Mouth X-rays	☐	____	____%	____%	____%
All Other X-rays	☐	____	____%	____%	____%
Brush Biopsy	☐	____	____%	____%	____%
Sealants	☐	____	____%	____%	____%
Minor Restorative	☐	____	____%	____%	____%
Endodontics	☐	____	____%	____%	____%
Periodontic Maintenance	☐	____	____%	____%	____%
Non-Surgical Periodontics	☐	____	____%	____%	____%
Surgical Periodontics	☐	____	____%	____%	____%
Relines and Repairs	☐	____	____%	____%	____%
Simple Extractions	☐	____	____%	____%	____%
Surgical Extractions	☐	____	____%	____%	____%
Other Oral Surgery	☐	____	____%	____%	____%
Other Basic Services	☐	____	____%	____%	____%
Major Restorative	☐	____	____%	____%	____%
Bridges	☐	____	____%	____%	____%
Dentures	☐	____	____%	____%	____%
Implants	☐	____	____%	____%	____%
TMD Treatment	☐	____	____%	____%	____%
Orthodontic Services	☐	____	____%	____%	____%

Orthodontic Age Limit: _____ **Adult:** ■ Yes ☐ No				
Ortho Max Amount: ☐ Lifetime ☐ Benefit Year		$____	$____	$____
Annual Max	$_____	**Allowed Amount Percentile:**_____%		
Deductible Amount: (Individual/Family)		____ / ____	____ / ____	____ / ____
Carry forward deductible met from Prior Carrier: ☐ Yes ☐ No		**Mid-Year Take Over:** ☐ Yes ☐ No		
Three-month deductible carryover?: ☐ Yes ☐ No				
Prenatal Benefit?: ☐ Yes ☐ No		**Max Rollover?:** ☐ Yes ☐ No		
Office Visit Fee: $_____		**Applies to:** _____		
Benefit Year: ☐ Calendar Year ☐ Policy Year ☐ Other: _____				
Evidence Based Dentistry: ☐ Yes ☐ No				

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VISION BENEFITS:

Benefit Plan Type: ☐ Choice Plan ☐ Other:_____

	In-Network			Out-Of-Network		
COVERED SERVICES	**Copay**	**Allowance/ Maximum**	**Frequency**	**Copay**	**Allowance/ Maximum**	**Frequency**
Eye Exam	____	____	____	____	____	____
Retinal Screening	____	____	____	____	____	____
Prescription Glasses	____	____	____	____	____	____
Frames	____	____	____	____	____	____
Lenses	____	____	____	____	____	____
Enhancement	____	____	____	____	____	____
Contact Lenses*	____	____	____	____	____	____
Necessary Lenses	____	____	____	____	____	____
Elective Lenses	____	____	____	____	____	____
Low Vision	____	____	____	____	____	____
Supplemental Aids	____	____	____	____	____	____
Supplemental Eye-care	____	____	____	____	____	____
Benefit Year: ☐ Calendar Year ☐ Service Year						

* Instead of Prescription Glasses

Rates per subscriber per month: *(check one)*

☐ One Tier ☐ Two Tier ☐ Three Tier ☐ Four Tier

Tier Description	**Dental Rates**	**Vision Rates**
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

ERISA Information Schedule A (Form 5500) required? ■ Yes ☐ No

REPORTS REQUIRED: *(Additional charges may apply)*

_____

_____

_____

_____

_____

SPECIAL INSTRUCTIONS:

_____

_____

_____

_____

_____

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AGREEMENT AND RECEIPT

The undersigned employer hereby adopts and subscribes to the terms and provisions in the application and to the terms and pro- visions of the Policy of which this application becomes a part. It is agreed that the employer has 15 days from the date of delivery of the Policy to return the Policy to Renaissance's corporate headquarters for a full refund. If the employer exercises this right, the Policy will terminate on the Effective Date as if no coverage was ever in force, and all money received will be returned.

In addition to the commissions and/or fees identified specifically for your Plan, the Agency or Agent may qualify for additional compensation payments from Renaissance related to your purchase of a Renaissance Policy. This additional compensation is not charged to your Group.

This application is subject to approval, refusal, or modification in accordance with Renaissance's guidelines. Misrepresentation of material fact or fraud will cause this application and subsequent Policy to be null and void from the start. **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).**

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

Check #_____in the amount of $_____to be applied as a credit toward the payment of the first month's premium on the proposed Renaissance Policy for which application is made. In case application is not accepted by Renaissance, the payment indicated here will be returned.

Signed this _____day of _____, 20 _____ at _____

Signature of Authorized Group Official: _____Title: _____

Signature of Agent:_____Lic. # :_____State:_____

Signature of Renaissance Representative:_____

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FOR AGENTS ONLY

Agent Name: _____

Agency Name:_____ **Agent License Number:** _____

Street Address:_____

City:_____ **County:** _____

State: _____ **ZIP Code:** _____ **Telephone:** (_____) _____ **Fax number:** (_____) _____

E-Mail Address:_____

New Agent/Agency? ☐ Yes ☐ No *(If yes, attach New Agent Documentation)*

Commission: ☐ Standard ☐ Split: ☐ 50/50 ☐ Other *(please indicate)*_____

2nd Agent Name *(if applicable)*: _____

Agency Name:_____ **Agent License Number:** _____

Street Address:_____

City:_____ **County:** _____

State: _____ **ZIP Code:** _____ **Telephone:** (_____) _____ **Fax number:** (_____) _____

E-Mail Address:_____

New Agent/Agency? ☐ Yes ☐ No *(If yes, attach New Agent Documentation)*

General Agent *(if applicable)*:_____

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Renaissance in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Renaissance. This requirement is a condition to eligibility for receiving compensation under Renaissance's Agency/Agent compensation program as described in Renaissance's Agency/Agent Agreement. Renaissance will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this Application I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Renaissance related to the client's purchase of a Renaissance benefit plan.

Signature of Agent: _____ **Date:**_____

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FRAUD WARNING NOTICES

(If you live in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Alaska: 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.

Alabama/Arkansas/Louisiana/New Mexico/Rhode Island/West Virginia: 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.

Arizona: 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.

California: 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.

Colorado: 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: 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**.**

Delaware/Idaho/Indiana: 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.

Florida: 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.

Georgia: 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.

Hawaii: 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.

Kansas: 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.

Kentucky: 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.

Maine/Tennessee/Washington: 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**.**

Maryland: 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.

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

New Hampshire: 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.

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

Ohio: 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.

Oklahoma: 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.

Oregon: 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.

Pennsylvania: 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.

Texas: 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.

Vermont: 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.

Virginia: 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.