Renaissance

DENTAL · VISION · LIFE · DISABILITY

P.O. Box 1596, Indianapolis, IN 46206

Renaissance Life & Health Insurance Company of America

FLORIDA

FOR RENAISSANCE USE ONLY:
Group #: _____

EMPLOYER APPLICATION FOR GROUP INSURANCE

—Please Type Or Print Clearly In Dark Ink—

☑ Dental ☑ Vision

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 (Renaissance).

- This form is for Employer groups only. Please contact us if applying for coverage for a union, group association or trust.
- 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 or plan design changes.

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

SECTION I | EMPLOYER INFORMATION

Full Legal Name of Employer:

Employer Tax ID No. *(EIN)*:	**Total Eligible Employees:** F/T: _____ P/T: _____	**Employer Status:** ☐ Corporation ☐ S Corp ☐ Partnership ☐ Proprietorship ☐ LLC ☐ Other: _____

Nature of Business:	**Years in Business:**	**SIC Code:**

Employer Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Employer Mailing Address *(If different from above)*:	**City:**	**State:**	**ZIP Code:**

SUBSIDIARIES, DIVISIONS, OR AFFILIATES TO BE COVERED: ☐ NONE ☐ LISTED BELOW

NAME	STREET ADDRESS	CITY	STATE	ZIP CODE	EIN

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Employer.

BILLING CONTACT	**Name:**	**Email:**
	Title:	**Telephone:**
		Fax:
GROUP ADMIN (IF DIFFERENT)	**Name:**	**Email:**
	Title:	**Telephone:**
		Fax:
CLAIMS CONTACT (IF DIFFERENT)	**Name:**	**Email:**
	Title:	**Telephone:**
		Fax:

SECTION II | EMPLOYEE INFORMATION

Domestic Partners: Are Benefits Extended To Domestic Partners? ☐ Yes ☐ No

If Employees Are Electing Benefits, Indicate How Elections Will Be Provided: ☐ Forms ☐ Electronic Media: *If Electronic, please specify type:* _____

Are Retired Employees To Be Included As A Class For Any Benefit? ☐ Yes ☐ No *(If yes, Renaissance approval required)*;
A retired Member/Employee is a formerly active Employee ☐ who has attained age _____ and has _____ years of service ☐ Other: _____

SECTION III | DENTAL AND VISION APPLICATION

Effective Date *(mm/dd/yy)*:

Anniversary Date *(mm/dd/yy)*:

Employer Contributions:
Employee Coverage? ☐ Yes ☐ No
Dependent Coverage? ☐ Yes ☐ No

If Yes, Employer Contributions Are:
Employee Coverage? Dental: _____% Vision: _____%
Dependent Coverage? Dental: _____% Vision: _____%

DENTAL AND VISION COVERAGE

☐ Dental
☐ Vision

Dental Benefit Year: ☐ Calendar Year ☐ Policy Year ☐ Other: _____
Vision Benefit Year: ☐ Calendar Year ☐ Service Year ☐ Other: _____

Section 125 Plan?: ☐ Yes ☐ No

Enrollee ID Cards should be sent to: ☐ Group ☐ Member Home

Can Employees Opt-out of Dental or Vision Plan?: ☐ Yes, Dental ☐ Yes, Vision ☐ No

DENTAL AND VISION ELIGIBILITY

Eligible Employees:

Enrolled Employees:

Is any class of full-time Employees to be excluded from coverage? ☐ Yes ☐ No *(If "Yes", list each class by salary, job title, union membership, or other conditions pertaining to employment)* _____

If Classes Of Employees Have Different Benefits For Dental/Vision Coverage, Define Classes In Chart Below, *OR* Indicate Initial Class As "All Eligible Employees."

CLASS	DESCRIPTION (SALARY, JOB TITLE, UNION MEMBERSHIP OR OTHER)	MINIMUM HOURS WORKED PER WEEK (LESS THAN 30 HOURS REQUIRES APPROVAL)

WAITING PERIODS (CHECK BOX & CIRCLE DAYS OR MONTHS AS APPLICABLE FOR CURRENT AND FUTURE EMPLOYEES)

CURRENT EMPLOYEES (HIRED ON OR BEFORE EFFECTIVE DATE)

☐ Waived at initial enrollment for _____
☐ 1st of month ***OR*** ☐ Day following _____Days / Months
☐ None ☐ Other: _____

Applies To All Classes? ☐ Yes ☐ No *(Please Define Below):*
_____

FUTURE EMPLOYEES (HIRED AFTER THE EFFECTIVE DATE)

☐ 1st of month ***OR*** ☐ Day following _____ Days / Months
☐ None ☐ Other: _____

Applies To All Classes? ☐ Yes ☐ No *(Please Define Below):*
_____

Is This Coverage Replacing Any Existing Group Insurance?
☐ Yes ☐ No *(If Yes, provide the carrier name and copy of a current bill and policy)*
☐ Bill & Policy Provided Carrier: _____

Benefits As Quoted In Attached Proposal Dated: _____
Proposal ID #:_____ ***OR*** **Benefits As Described in Prior Carrier Policy** Policy Number: _____

THIS POLICY PROVIDES DENTAL AND/OR VISION BENEFITS ONLY. PLEASE REVIEW YOUR POLICY CAREFULLY. *This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.*

SECTION IV | BILLING PREMIUM PAYMENTS & REPORTING

If Your Employees Are Paying All Or Most Of The Premium, You May Choose To Have Your Bill Based On Your Employees' Payroll Cycle. Your Billing Statement Will Reflect The Amount Due For Each Employee Based On The Number Of Pay Periods That The Employee Is Scheduled For That Calendar Month. Please Indicate Your Payroll Cycle:

☐ Monthly (12)

For Voluntary Coverage, The First Deduction Period Will Start On: _____ *(mm/dd/yyyy)*

Please Indicate How Your Bill Should Be Structured:

☐ Single bill with all Employees and coverages

☐ Single bill with Employees grouped by location

☐ Multiple bills split by location

How Would You Like To Receive Your Bill? ☐ Online ☐ Email (PDF) ☐ Paper mailed to you

REPORTS REQUIRED (ADDITIONAL CHARGES MAY APPLY)

SPECIAL INSTRUCTIONS

DEPOSIT

ATTACHED IS A DEPOSIT OF $ _____WHICH WILL BE CREDITED TO THE FIRST PREMIUM DUE ONLY IF THE INSURANCE AS APPLIED FOR HEREUNDER IS APPROVED BY RENAISSANCE, AND IF INSURANCE IS NOT APPROVED, THE DEPOSIT WILL BE REFUNDED.

ELECTRONIC DELIVERY OF POLICY DOCUMENTS

☐ By checking this box, you acknowledge your consent to receive electronic copies of Renaissance plan materials and related documents pursuant to the Terms for Paperless Delivery attached to this application form, and in lieu of paper copies, to the extent permitted by applicable law.

You understand that you must provide a current email address on the first page of this application form. You may change this election by providing Renaissance thirty (30) days' prior written notice.

SECTION V | POLICYHOLDER AGREEMENT

I understand that the Policy for which I am applying includes minimum participation requirements. If a sufficient number or percentage of eligible Employees fail to enroll and the minimum participation requirements for issuance of the Policy are not met, the insurance will not become effective.

If Employees are paying all or a portion of the premiums, we agree to deduct applicable premiums from the payroll and remit to Renaissance on a monthly basis.

I agree to accept the terms and provisions of the Policy, including its exhibits, riders, endorsements or amendments, if any. I understand that no insurance is effective until after this application is accepted by Renaissance or the effective date of coverage, whichever is later. I understand that no agent or broker may change or waive any of the provisions of this application. I further understand that Renaissance may not be designated as the "Plan Administrator" or "Fiduciary" of the employee welfare benefit plan under ERISA.

I have read and understand this entire application. The information provided is accurate to the best of my knowledge. I understand that the information on this application and any other information I provide shall serve as the basis for the insurance to be issued. I have a duty to notify Renaissance of any changes. I further understand that the Benefits provided by Renaissance to my Employees and their Dependents are based on the information I provide. I understand that in the event of a conflict between any proposals provided and the policy issued by Renaissance the terms of the policy will prevail. It is understood and agreed that this application shall be made a part of the Policy applied for and that no insurance shall be effective until approved by Renaissance at its Home Office.

I understand that the tax consequences to the Employer and the Employee depend on a variety of factors, including the responses to the questions set forth in this application. I have not relied on Renaissance or any of its agents or Employees for purposes of assessing these tax consequences and am relying exclusively on my tax advisor in this regard.

I UNDERSTAND THAT THE LAWS OF THE STATE OF FLORIDA WILL GOVERN THE POLICY. ***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.***

Printed Name and Title of Authorized Group Official: _____

Signature of Authorized Group Official: *X* _____ Date: _____

SECTION VI | FOR AGENTS ONLY

TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE AND BELIEF, ALL THE STATEMENTS AND ANSWERS GIVEN IN THIS APPLICATION ARE TRUE AND COMPLETE. THE UNDERSIGNED HAS NO KNOWLEDGE OR INFORMATION ABOUT THE EMPLOYER, THE EMPLOYEES, OR DEPENDENTS OF SUCH EMPLOYEES THAT IS INCONSISTENT WITH ANY STATEMENT MADE IN THIS APPLICATION.

Replacement Of Life Insurance Is Or May Be Involved In This Transaction? ☐ Yes ☐ No

AGENT COMMISSION	STANDARD OR SPLIT		IF SPLIT SELECTED: 50/50 OR OTHER		DEFINE IF OTHER
Life + AD&D	☐ Standard	☐ Split	☐ 50/50	☐ Other	
Short-Term Disability (STD)	☐ Standard	☐ Split	☐ 50/50	☐ Other	
Long-Term Disability (LTD)	☐ Standard	☐ Split	☐ 50/50	☐ Other	
Dental	☐ Standard	☐ Split	☐ 50/50	☐ Other	
Vision	☐ Standard	☐ Split	☐ 50/50	☐ Other	

Soliciting Agent(s)

Printed Name: _____

Signature: _____ Date: _____

FL Agent License #: _____

General Agent(s) *(If Applicable)*

Printed Name: _____

Signature: _____ Date: _____

FL Agent License #: _____