



Dental and Vision Eligibility Enrollment/Change/Waiver

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

Effective Date of Change (if applicable): Change is for: Subscriber Dependent(s)

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:

Street Address: Suite/Apartment:

City: State: ZIP Code:

E-mail Address: Phone:

Company Name: Job Title:

Birth Date: Date of Hire: Coverage Effective Date:

Spouse/Domestic Partner/Dependent Information—please fill in all information for first-time enrollment or corrections

Table with 7 columns: Print Full Legal Name, Relationship, Dental (add/drop), Vision (add/drop), Birth date, Status. Rows include Spouse/Domestic Partner and Dependents One through Four.

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. By signing below, I consent to electronic delivery of my certificate of coverage and related documents 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.

For your protection California law requires the following to appear on this form. 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.

Subscriber Signature: _____ Date: _____

WAIVE COVERAGE—*if you're 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/Domestic Partner Child(ren) Only

I hereby certify that I understand that I am eligible for the dental and/or vision coverage offered by Renaissance Life & Health Insurance Company of America. I hereby decline coverage.

Printed Name: _____ Signature: _____

Name of Employer: _____ Date: _____

IF RENAISSANCE COVERAGE IS WAIVED BECAUSE OF COVERAGE THROUGH ANOTHER SOURCE:

Name of Other Dental/Vision Carrier: _____

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

HELPFUL TIPS—*If you have any questions completing this form, your 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 subscriber. 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 self-paid continuous coverage with COBRA. (employers may be required to offer the self-paid extended coverage to certain employees/beneficiaries who qualify and lose their health care benefits coverage. Confirm with your Human Resource/Personnel Department.)*
- **Surviving**—*surviving dependent of a deceased subscriber.*

TYPE OF UPDATE—*please select all that apply*

- **Waive**—*waiving benefits for yourself or dependents.*
- **New Enrollment**—*first time enrolling yourself or dependents.*
- **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 dependents.*

SPOUSE/DOMESTIC PARTNER/DEPENDENT

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

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

- **Surviving**—*surviving dependent of a deceased subscriber.*
- **Legal**—*an individual over 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 his/her coverage would otherwise end because of age.*



DENTAL · VISION · LIFE · DISABILITY

Underwritten by Renaissance Life & Health Insurance Company of America, 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.