DENTAL · VISION · LIFE · DISABILITY

[P.O. Box 1596 Indianapolis, IN 46206]

FLORIDA
Renaissance Life & Health
Insurance Company of America

Employer *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 *(Renaissance)*.

- 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 area is for Renaissance use only)

Group Number: ____________________ **Group Name:** ____________________

Sub-Group Names *(if applicable)*: ____________________

Requested Effective Date: ____________________ Renewal Date: ____________________

Amount Paid By Employer For: Employee Coverage: ____________ Dependent Coverage: ____________

Definition Of Subscriber *(for example: "all full-time employees, all full-time and part-time employees.")*: ____________________

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 Number of Eligible Employees: ____________

Estimated Number of Employees Enrolling: ________ Benefit Year: ☐ Calendar Year ☐ Policy Year ☐ Other: ____________

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: ____________________ State: ____________ Zip Code: ____________

County: ____________________ Telephone: ____________ Fax Number: ____________

Billing Contact: ____________________ Title: ____________________

E-Mail Address: ____________________

Billing Address *(if different from above)*: ____________________

City: ____________________ State: ____________ Zip Code: ____________

Group Administrator: ____________________ Title: ____________________

E-Mail Address: ____________________

Previous Carrier: ☐ No ☐ Yes *If Yes, Please Indicate Carrier:* ____________________

Enrollment By: ☐ Form ☐ Electronic Media *If Electronic Media, Please Specify Type:* ____________________

Delivery Method For The Group Policy, Individual Subscriber Certificate And Summary: ☐ Electronic ☐ Paper

If Paper Method Is Selected, Send Materials To: ____________________

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.

Enrollee ID Cards Sent To: ☐ Group ☐ Member Home

IMPORTANT NOTE: PROPOSAL MUST BE ATTACHED FOR APPLICATION TO BE COMPLETED.

Benefits Included In Proposal *(check all that apply)*: ☐ Dental ☐ Vision Proposal Attached: ☐ Yes

ERISA Information Schedule A (Form 5500) Required?: ☐ Yes ☐ No

Reports Required *(additional charges may apply)*: ____

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Special Instructions: ____

____

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(Shaded Area for Agents Only) New Agent/Agency?: ☐ Yes ☐ No *(if yes, attach New Agent Documentation)*

Agent Name: ____________________ Agency Name: ____________________

FL License Number: ____________________ County: ____________________

Street Address: ____________________ City: ____________________

State: _________ ZIP Code: _____________ Telephone: ____________________ Fax number: ____________________

E-Mail Address: ____

Commission: ☐ Standard ☐ Split *(if split please check one that applies)*: ☐ 50/50 ☐ Other *(please indicate)*____________________

2nd Agent Name *(if applicable)*: ____________________ Agency Name: ____________________

FL License Number: ____________________ County: ____________________

Street Address: ____________________ City: ____________________

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:** ____________________

AGREEMENT AND RECEIPT

The undersigned [employer] hereby adopts and subscribes to the terms and provisions in the application and to the terms and provisions 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 benefit 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 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 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.**

This type of plan in 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.

THIS POLICY PROVIDES [DENTAL AND/OR 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: ____________________________________ License # : ________________ State: __________

Signature of Renaissance Representative: ____

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