Renaissance℠

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 or Renaissance Health Insurance Company of New York (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 or Renaissance, please feel free to contact your Renaissance representative.

(Shaded areas are for Renaissance use only)

Group Number _____

Group Name _____

Requested Effective Date _____ Renewal Date _____

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

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

Are any classes excluded? ☐ Yes ☐ No or Is this a Management Carve-out? ☐ Yes ☐ No

If yes, explain _____

Number of Eligible Employees _____ Number of Employees Enrolling _____

New Employee Waiting Period: First of the month following _____ days

Waived at initial enrollment? ☐ Yes ☐ No

Group Address _____

City _____ County _____

State _____ Zip Code _____

Telephone ( ) _____ Fax Number ( ) _____

Billing Address (if different from above) _____

City _____ State _____ Zip Code _____

Group Officer Mr. Ms. Dr. _____ Title _____

Group Contact Mr. Ms. Dr. _____ Title _____

E-Mail Address _____ Tax Identification Number _____

Type of Industry _____ NAICS Code _____

Send materials to _____

Account Executive _____ Industry Code _____

Account Service Manager _____ Underwriter _____

Previous Carrier ☐ None ☐ Yes (indicate carrier) _____

Enrollment by ☐ Form ☐ Electronic Media (specify) _____

Standard Materials include Certificate, Summary, and ID Cards

Other materials requested _____
(additional charges may apply)

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

_____

_____

BENEFITS

Benefit Plan Type: ☐ Indemnity FFS ☐ Indemnity Schedule ☐ Preferred Provider (PPO)

(Please attach copy of proposal)	**Indemnity Fee For Service**	**Preferred Provider (PPO)**	
		In-Network	**Out-of-Network**
Diagnostic			
Preventive			
Bitewing Radiographs			
Space Maintainers			
Sealants			
All Other Radiographs			
Emergency Palliative			
Simple Extractions			
Minor Restorative			
Endodontics			
Periodontics			
Major Oral Surgery			
Major Restorative			
Prosthodontics			
Relines and Repairs			
Implants			
Orthodontics			
TMJ Appliances			

Annual Maximum Amount $ _____ Allowed Amount _____

Orthodontic Age Limit ☐ Standard (19) ☐ Other _____

Orthodontic Lifetime Maximum Amount $_____

Deductible: $ _____ per person per year limited to a maximum of $ _____ per family per year

(check one) ☐ Calendar Year ☐ Contract Year

Deductible is Applicable to ☐ All Services ☐ All Services Except _____

Three-Month Deductible Carry-over? ☐ Yes ☐ No Deductible Credit from Prior Carrier? ☐ Yes ☐ No

VISION: Enhanced ☐ Yes ☐ No Plus Plan: ☐ Yes ☐ No

RATES PER SUBSCRIBER PER MONTH

(check one) ☐ 1 Tier ☐ 2 Tier ☐ 3 Tier ☐ 4 Tier

Tier Description

_____ $_____

_____ $_____

_____ $_____

_____ $_____

ADMINISTRATIVE SERVICES ONLY (ASO) FEES

☐ Percentage of Claims _____

☐ Per Capita $ _____

☐ Per Transaction $ _____

☐ 1 Month Prefund $ _____

CONTRACT TYPE

☐ Non-Retention

☐ Administrative Services Plan

☐ Aggregate Stoploss _____ %

Administration _____ % (use one year administration only)

☐ Other _____

History Crosscheck _____

ERISA Information Schedule A (Form 5500) required? ☐ Yes ☐ No Time Period _____

REPORTS REQUIRED

_____

_____

_____

SPECIAL INSTRUCTIONS

_____

_____

_____

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 contract of which this application becomes a part. It is agreed that the employer has 15 days from the date of delivery of the contract to return the contract to Renaissance's corporate headquarters for a full refund. If the employer exercises this right, the contract will terminate on the effective date as if no coverage or administrative services were ever in force, and all money received will be returned. This application is subject to approval, refusal, or modification in accordance with Renaissance's guidelines. Misrepresentation or fraud will cause this application and subsequent contract to be null and void from the start. Any person, who knowingly and with intent to injure, defraud, or deceive any insurer, or files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree. **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.**

Check #_____ in the amount of $_____ to be applied as a credit toward the payment of the first month's premium on the proposed Renaissance program 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 _____

Renaissance Life & Health Insurance Company of America
Renaissance Health Insurance Company of New York

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) _____