Renaissance®

DENTAL · VISION · LIFE · DISABILITY

GROUP ACCIDENT CLAIMANT STATEMENT

—Please Type Or Print Clearly In Black or Blue Ink—

INSTRUCTIONS AND ADDITIONAL INFORMATION:

THIS FORM MAY BE USED FOR BOTH EMPLOYEE/MEMBER, SPOUSE AND DEPENDENT CLAIMS

- The Group Accident Claimant Statement is to be completed by the Employee/Member. Please complete this form in its entirety. **Incomplete Forms will be Returned and may Result In a Delay In Processing Your Claim.**
- In the event of the accidental death of the Employee/Member within 90 days of a covered accident and as a result of injuries received from that covered accident:
  - This form is to be completed by the beneficiary named on the Accident Insurance Enrollment Form or as later changed by the Employee/Member.
  - An original death certificate must be included with the completed Claimant Statement.
- When the claim is for an accident involving a covered Spouse, Domestic Partner, or Dependent Child, additional signatures are required. If the Claimant is a covered Spouse, Domestic Partner, or Dependent Child 18 years of age or older, they must sign as the Claimant in the signature portion of this form. If the claim is for a covered Dependent Child under age 18, the Employee/Member must sign for the minor Claimant. Please refer to the signature section at the end of this form.
- When the claim is for an accident involving a Dependent Child, please include a photocopy of his or her birth certificate. When the claim is for an accident involving a Dependent Child you adopted, please include copy of the adoption papers. In place of a birth certificate or adoption papers, other forms of proof may be acceptable *(i.e. Baptismal Certificate, financial responsibility for the medical expenses incurred as a result of the covered accident).*
- Please attach photocopies of the initial itemized doctor, hospital, ambulance, emergency room, physical therapy bills and any other itemized documentation of expenses that were incurred as a result of the accident. Benefits are paid based on the individual services received from your medical providers along with the diagnosis indicated. We must have copies of the original billing that indicates the diagnosis, individual services received *(i.e. X-ray, MRI, dates of actual physical therapy, etc)*, and actual charges. You do not need to send the original bills, photocopies are acceptable. Do not send balance due notices.
- If injury was a result of a motor vehicle accident, please include a copy of the police report. For any incidents investigated by any law enforcement agency, please include a copy of the report.
- Please read the Claim Fraud Warnings Page attached to this Claimant Statement prior to signing this form.

Questions? Please Contact Us At:
Telephone: 844-368-6485
Email: GroupClaims@RenaissanceFamily.com

Please Mail or Fax Completed Forms with ALL Supporting Documents To:
Renaissance
Group Claims, 2 Court Street, Suite 102, Binghamton, NY 13901 | Or Secure Fax: 607-773-2276

SECTION I | PRIMARY INSURED EMPLOYEE/MEMBER INFORMATION

Employee/Member Name:	**Policy Number:**		
Employee Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Date of Birth *(mm/dd/yyyy)*:	**Social Security Number:**		
Daytime Telephone Number:	**Evening Telephone Number:**		
Email Address:	**Sex:** ☐ Male ☐ Female		

SECTION II | CLAIMANT INFORMATION

PLEASE COMPLETE IF CLAIM IS FOR A SPOUSE, DOMESTIC PARTNER, OR DEPENDENT CHILD

Claimant Full Name:	**Social Security Number:**		
Address If Different From Employee/Member *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Date of Birth *(mm/dd/yyyy)*:	**Sex:** ☐ Male ☐ Female		

Beneficiary's Relationship to Employee/Member: ☐ Spouse ☐ Domestic Partner ☐ Dependent Child

If a Dependent Child Under 19 Years of Age, Please Answer the Following Questions:

Does Dependent Live with You? ☐ Yes ☐ No

Is Dependent Chiefly Dependent Upon You for Maintenance and Support? ☐ Yes ☐ No

Is Dependent Child Married? ☐ Yes ☐ No

If a Dependent Child 19 Years of Age or Older, Please Answer the Following Questions:

Is Dependent Chiefly Dependent Upon You for Maintenance and Support? ☐ Yes ☐ No

Is Dependent a Full Time Student at an Accredited Secondary School, College or University? ☐ Yes ☐ No

If Yes: Name of School: _____

Number of Credit Hours Per Semester: _____

Is Dependent Child Married? ☐ Yes ☐ No

SECTION III | ACCIDENT INFORMATION

Date of Accident *(mm/dd/yyyy)*:	**Location of Accident:**

Explain How the Accident Happened and the Resulting Injuries:

Was the Claimant Working for Pay or Profit When the Accident Occurred? ☐ Yes ☐ No

If Yes, is the Injury Covered by Worker's Compensation? ☐ Yes ☐ No

If Yes, What is the Status of the Claim? ☐ Approved ☐ Pending ☐ Denied

Has a Claim Been Filed in the Past 12 Months for Same Type of Accident? ☐ Yes ☐ No

Name of Treating Physician:

Treating Physician Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Treating Physician Telephone Number:	**Treating Physician Email Address:**		

SECTION IV | BENEFICIARY'S INFORMATION (COMPLETE ONLY IN THE EVENT OF AN ACCIDENTAL DEATH OF THE EMPLOYEE)

Beneficiary(ies) Full Name:	Social Security Number:		Telephone Number:
Address *(Include Apt#/Suite)*:	City:	State:	ZIP Code:
Date of Birth *(mm/dd/yyyy)*:	Date of Death *(mm/dd/yyyy)*: *PLEASE SUBMIT AN ORIGINAL DEATH CERTIFICATE*		

Enter the Taxpayer Identification Number in the Appropriate Box Below. For Most Individuals This is Your Social Security Number.

INDIVIDUAL	ESTATE OR TRUST
Social Security Number:	Employer Identification Number:

Check Appropriate Box for Federal Tax Classification: ☐ Individual/Sole Proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate ☐ Limited Liability Company.

Enter the Tax Classification (C=C Corporation, S=S Corporation, P=Partnership): _____**Other:**_____

Exemptions: Exempt payee code (If Any): _____ **Exemption from FATCA reporting code** (If Any): _____

CERTIFICATION

CERTIFICATION INSTRUCTIONS. -You must cross out item (2) below if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Under the penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (including a U.S. resident alien), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

SIGNATURES

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution, or person who has attended me or has any records or knowledge of me or my health to furnish the Renaissance Life & Health Insurance Company, or its representatives, and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is valid for the duration of my claim for benefits.

FRAUD WARNING: IT IS OR MAY BE A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY OR ANY OTHER PERSON. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE IN ACCORDANCE WITH APPLICABLE STATE LAW. PLEASE CAREFULLY REVIEW THE "CLAIM FRAUD WARNING STATEMENTS' PAGE, ATTACHED TO AND INCORPORATED HEREIN BY REFERENCE (SEE STATE SPECIFIC FRAUD WARNINGS ATTACHED).

The undersigned declares that the foregoing statements are true and complete and agrees to furnish additional information and documentation as may be required. It is understood that the furnishing of forms by the company does not constitute an admission of liability. I (we) have read the fraud notice page included with this form.

Primary Insured Printed Name | **Date of Birth** *(mm/dd/yyyy)*

X
Primary Insured Signature | **Date Signed** *(mm/dd/yyyy)*

Claimant Printed Name | **Date of Birth** *(mm/dd/yyyy)*

X
Claimant Signature *(If Claimant is Under 18 Years of Age, Signature of Primary Insured/Legal Representative.)* | **Date Signed** *(mm/dd/yyyy)*

Beneficiary Printed Name | **Phone Number**

X
Beneficiary Signature (*In Event of Accidental Death)* | **Date Signed** *(mm/dd/yyyy)*

STATE FRAUD WARNING STATEMENTS:

The laws of the states beneath require the Company to provide the following statements:

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

AK: A 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.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI and WV: 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.

CA: 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.

CO: 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.

CT: 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.

DE: 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.

DC: WARNING: It is a crime to provide false or misleading information to any 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.

FL: 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.

ID: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN: A person who knowingly and with intent to defraud a insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MA: 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 a denial of insurance benefits.

MD: 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.

ME: 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 a denial of insurance benefits.

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

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in NH R.S.A. REV Stat ANN 638.20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: 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 civil fines and criminal penalties.

NY: 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.

OH: Any person who, with intent to defraud or knowing that he 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

OK: WARNING: 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. Penalties may include imprisonment, fines or a denial of insurance benefits.

PA: 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.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

TX: 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.

VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.