Renaissance®

DENTAL · VISION · LIFE · DISABILITY

GROUP LIFE INSURANCE CLAIM FORM WAIVER OF PREMIUM

—Please Type Or Print Clearly In Dark Ink—

INSTRUCTIONS:

This form is to be completed by the employee, employer and the attending physician. Benefits are considered on a bi-weekly basis subject to receipt of required proof of medical evidence by your doctor. To avoid delay, please return the completed form promptly.

If you are an employee covered by Renaissance Group Term Life and you are no longer able to work due to a disability, you may be eligible to have your life insurance premium waived while you are totally disabled. *(Please check with your employer that the Waiver of Premium benefit is available to you prior to completing the form.)* To determine if you are qualified to receive this benefit, please complete this form for yourself and then have your employer and your physician complete their sections. Submit the fully completed form to us at the address provided. Incomplete information will delay the determination of your eligibility.

SECTION I | EMPLOYEE STATEMENT

Full Name *(Last, First, MI)*:	**Social Security Number:**		
	Phone:		
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**Zip Code:**
Date of Birth *(mm/dd/yyyy)*:	**Job Title/Occupation:**		
Employer Name:			
Employer Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**Zip Code:**
Date Last Worked *(mm/dd/yyyy)*:	**Date of Sickness or Accident** *(mm/dd/yyyy):*		
Nature of Sickness or Injuries:			
If Injury; How and Where Did Accident Happen:			
Have You Had the Same or Similar Sickness or Injury Before? ☐ Yes ☐ No *(If Yes; Give Dates and Details Below)*			
Hospital Name *(If Admitted to the Hospital Regarding this Disability, Complete)*:	**Date Admitted** *(mm/dd/yyyy)*:		
Physician Name:	**Date Discharged** *(mm/dd/yyyy):*		
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**Zip Code:**

SECTION I | EMPLOYEE STATEMENT (CONTINUED)

Date You First Resumed Any Duties *(mm/dd/yyyy)*:	If Not Resumed, When Do You Expect To *(mm/dd/yyyy)*:

If Still Disabled, Describe Present Activities:

What Other Disability Insurance Do You Have:	Amount(s):

Other Insurance Company Name:

Street Address *(Include Apt#/Suite)*:	City:	State:	Zip Code:

X _____ _____

Signature *(Required)* **Date Signed** *(mm/dd/yyyy)*

SECTION II | EMPLOYER OR PLAN ADMINISTRATOR STATEMENT

Name of Employee *(Last, First, MI)*:	Date of Birth *(mm/dd/yyyy)*:	Date Employed *(mm/dd/yyyy)*:
Social Security Number:	Policy Number(s):	

Occupation:	Date Last Worked:	Reason For Leaving Work:
Base Annual Compensation: *(As Defined in the Policy)*		☐ Disability ☐ Lay Off ☐ Retired ☐ Dismissed ☐ Quit ☐ Leave ☐ Other: _____

Date Returned to Work *(mm/dd/yyyy)*:	If Not, Expected Date *(mm/dd/yyyy)*:

Effective Date of Employee's Insurance *(mm/dd/yyyy)*:	Date of Termination of Insurance *(mm/dd/yyyy)*:
Amount of Insurance On Last Day of Active Employment:	Classification:

Is Employee Entitled to Workers' Compensation For This Disability? ☐ Yes ☐ No

Name of Employer:

Street Address *(Include Apt#/Suite)*:	City:	State:	Zip Code:

X _____ _____

Signature *(Required)* **Date Signed** *(mm/dd/yyyy)*

SECTION IIII | ATTENDING PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER STATEMENT

Patient's Name *(Last, First, MI)*:	**Date of Birth** *(mm/dd/yyyy)*:

Nature of Sickness or Injuries *(Describe Complications, If Any)*:

When Did Symptoms First Appear or Accident Happen *(mm/dd/yyyy)*:	**When Did Patient First Consult You For This Condition** *(mm/dd/yyyy)*:
Date of First Treatment *(mm/dd/yyyy)*:	**Date of Most Recent Treatment** *(mm/dd/yyyy):*

Is Employee Entitled to Workers' Compensation For This Disability? ☐ Yes ☐ No
If Yes, State When and Describe:

Nature of Surgery, If Any *(Describe Fully)*:

How Long Was or Will Patient Be Continuously Totally Disabled *(Unable to Work)*:	**From** *(mm/dd/yyyy)*:
	Through *(mm/dd/yyyy)*:

Hospital Name:	**Date Admitted** *(mm/dd/yyyy)*:
	Date Discharged *(mm/dd/yyyy):*

Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**Zip Code:**

Hospital Name:	**Date Admitted** *(mm/dd/yyyy)*:
	Date Discharged *(mm/dd/yyyy)*:

Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**Zip Code:**

Remarks:

Printed Name of Attending Physician, Physician Assistant, or Nurse Practitioner

X
Signature of Attending Physician, Physician Assistant, or Nurse Practitioner **Date Signed** *(mm/dd/yyyy)*

Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**Zip Code:**

Phone:	**Degree/Specialty:**

STATE FRAUD WARNING STATEMENTS: THE LAWS OF THE STATES BENEATH REQUIRE THE COMPANY TO PROVIDE THE FOLLOWING 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: 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 an 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: 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.

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.

PR: Any person who knowingly and with the intention of defrauding presents false information to an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are [sic] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.