Renaissance®

DENTAL · VISION · LIFE · DISABILITY

2 Court Street, Suite 102, Binghamton, NY 13901

HOME OFFICE USE ONLY:

RELEASED BY: _____

RECEIVED BY: _____

GROUP ACCELERATED DEATH BENEFITS APPLICATION & CLAIM FORM

—Please Type Or Print Clearly In Dark Ink—

INSTRUCTIONS

Ⓐ **THERE ARE FOUR (4) PRIMARY SECTIONS TO BE COMPLETED IN THIS FORM. ALL SECTIONS MUST BE SIGNED AND DATED:**

- **SECTION 1:** Disclosure Statements and Application to Accelerate Benefits
- **SECTION 2:** Claimant Statement
- **SECTION 3:** Employer or Plan Administrator Statement
- **SECTION 4:** Attending Physician, Physician's Assistant, Nurse Practitioner Statement

Ⓑ **SEND COMPLETED FORM TO RENAISSANCE GROUP CLAIMS:**

- **BY MAIL:** 2 Court Street, Suite 102, Binghamton, NY 13901

  OR
- **BY SECURE FAX:** 607-773-2276
- **BY SECURE EMAIL:** groupclaims@renaissancefamily.com

Ⓒ **HAVE QUESTIONS OR NEED ASSISTANCE COMPLETING THIS FORM?**

- **CONTACT CLAIMS AT:** 844-368-6485 *(Option 2)*

SECTION I | DISCLOSURE STATEMENT AND APPLICATION TO ACCELERATE BENEFITS

1. Receipt of Accelerated Death Benefits ("ADB") may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for ADB, you should consult with the appropriate social services agency concerning how receipt will affect your eligibility and/or your spouse or dependents.
2. Receipt of ADB may be taxable. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.
3. Your application for an ADB is voluntary on your part and without coercion on the part of any third party.
4. **FOR NY RESIDENTS ONLY:** No health care facility as defined in Section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.
5. **FOR NY RESIDENTS ONLY:** Renaissance is prohibited from paying ADB to you, the Certificate Holder, for a period of 14 days from the date the information specified in New York State Regulation 143 is provided to you by Renaissance. Such information to be provided to
within 5 days of our receipt of this application.
6. Renaissance certifies that no later than at the time of application for the accelerated death benefit, a written benefit payment notice will be provided to you. The notice will show the following: 1) the face amount of the benefit. 2) the percentage of acceleration; 3) the amount of the benefit you will receive, less the applicable discount; and 4) the remaining death benefit.

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA AND IN NEW YORK, RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF NEW YORK ("RENAISSANCE") HERBY CERTIFIES THAT ALL THE INFORMATION INCLUDED HEREIN AND IN THE BENEFIT PAYMENT NOTICE WILL BE BASED ON CONTRACT GUARANTEES.

SECTION I.A | APPLICATION TO ACCELERATE BENEFITS

IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF THE **GROUP TERM LIFE INSURANCE ACCELERATED DEATH BENEFIT (ADB) COVERAGE**, I HEREBY APPLY FOR AN ADB. I UNDERSTAND THAT THE REMAINING DEATH BENEFIT AVAILABLE TO MY BENEFICIARY WILL BE REDUCED BY THE AMOUNT OF THE ADB PAID AND THE APPLICABLE DISCOUNT. ALTHOUGH THERE IS NO SEPARATE IDENTIFIABLE PREMIUM ASSOCIATED WITH THE ACCELERATED PAYMENT, THERE IS A DISCOUNT ASSOCIATED WITH ACCELERATION.

TO BE VALID, THIS APPLICATION MUST BE SIGNED BY YOU, THE CERTIFICATE HOLDER, NOT MORE THAN 30 DAYS AFTER THE DATE THIS APPLICATION IS TRANSMITTED TO YOU, SUCH RELEASE DATE SHOWN ABOVE IN THE SECTION LABELED "HOME OFFICE USE ONLY." IF WITHIN THE 30 DAY TIME PERIOD, THE APPLICANT WISHES TO WITHDRAW HIS OR HER ELECTION, HE OR SHE CAN DO SO WITHOUT PENALTY OR COST.

Date at: _____ **This:** _____ **Day of:** _____, _____.
(City and State) *(Day)* *(Month)* *(Year)*

Witness Printed Name *(Last, First, MI)*:	**Witness Signature** *(Required)*:
Certificate Holder Full Name *(Last, First, MI)*:	**Certificate Holder Signature** *(Required)*:

SECTION I | EMPLOYEE INFORMATION

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	**Social Security Number:**	
		D.O.B *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married		**Phone Number:**	
		Email:	
Date of First Treatment *(mm/dd/yyyy)*:		**Nature of Sickness Or Injuries:**	
Date of Sickness or Accident *(mm/dd/yyyy)*:			
Benefit Percent Requested: _____%			
Have You Filed For Bankruptcy? ☐ Yes ☐ No			
Have You Applied for Portability? ☐ Yes ☐ No		**Have You Applied For Conversion?** ☐ Yes ☐ No	

Do You Attest that Your State of Health is Such That Your Life Expectancy is Twelve Months or Less? ☐ Yes ☐ No

SECTION I.A | TREATING PHYSICIANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS:

Full Name *(Last, First, MI)*:		**Date of First Treatment** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Full Name *(Last, First, MI)*:		**Date of First Treatment** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Full Name *(Last, First, MI)*:		**Date of First Treatment** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

SECTION I.B HOSPITALS:

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:**

SECTION I.B | APPLICANT AUTHORIZATION

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY, THE MIB, INC., OR OTHER ORGANIZATION, INSTITUTION OR PERSON WHO HAS ATTENDED ME OR HAS ANY RECORDS OR KNOWLEDGE OF ME OR MY HEALTH TO FURNISH RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA AND RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF NEW YORK OR THEIR REPRESENTATIVE, ANY 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 PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT MAY BE TAXABLE AND MAY AFFECT ELIGIBILITY FOR TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. ASSISTANCE FROM A TAX ADVISOR IS RECOMMENDED.

Date at: _____ **This:** _____ **Day of:** _____, _____.
(City and State) *(Day)* *(Month)* *(Year)*

Applicant Signature *(Required)*:

SECTION II | EMPLOYER OR PLAN ADMINISTRATOR STATEMENT

Employer Name:			**Policy Number:**
Street Address *(Include Suite)*:	**City:**	**State:**	**ZIP Code:**
Phone:	**Email:**		**Fax Number:**
Employee Name *(Last, First, MI)*:			**Classification:**
Employee Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Employee Social Security Number:			**Job Title/Occupation:**
Date of Employment *(mm/dd/yyyy)*:			**Effective Date of Employee's Insurance** *(mm/dd/yyyy)*:
Base Annual Compensation *(As Defined in the Policy):* $ _____			**Amount of Insurance on Last Day of Active Employment:** $ _____
Date Last Worked *(mm/dd/yyyy)*:	**Reason for Leaving Work:** ☐ Disability ☐ Lay Off ☐ Dismissed ☐ Quit ☐ Leave ☐ Retired ☐ Other_____		

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED ON THE NAMED EMPLOYEE IS ACCURATE.

Date at: _____ **This:** _____ **Day of:** _____, _____.
(City and State) *(Day)* *(Month)* *(Year)*

Printed Name of Authorized Employer Representative:	**Authorized Employer Representative Job Title:**

Signature of Authorized Employer Representative *(Required)*:

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

Physician, Physician Assistant or Nurse Practitioner Name *(Last, First, MI)*:			**Tax ID Number:**
Street Address *(Include Suite)*:	**City:**	**State:**	**ZIP Code:**
May Our Medical Director Contact You? ☐ Yes ☐ No **If "Yes", Phone:** _____	**Fax:** **Email:**		
Patient's Name *(Last, First, MI)*:			**Date of Birth** *(mm/dd/yyyy)*:
Nature of Sickness or Injuries *(Describe Complications, If Any)*:	**Date Symptoms Appeared or Date of Accident** *(mm/dd/yyyy)*: **Date First Consulted for This Condition** *(mm/dd/yyyy)*:		

SECTION III.A | HOSPITALIZATIONS:

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:**
Briefly Describe The Course of Treatment to Date:	**Additional Comments:**		

Do you attest that the patient's state of health is such that the patient's life expectancy is 12 months or less? ☐ Yes ☐ No
(Please submit documentation supporting your position)

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED ON THE NAMED EMPLOYEE IS ACCURATE.

Date at: _____ **This:** _____ **Day of:** _____, _____.
(City and State) *(Day)* *(Month)* *(Year)*

License Number:	**License State:**
Physician, Physician Assistant or Nurse Practitioner Signature *(Required)*:	

–State Fraud Warnings on Following Page–

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.