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 from 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 section I, have your employer complete section II, and have your physician complete section III. Please send the fully completed form:

- **BY MAIL:** PO Box 1596 Indianapolis, IN 46206
- **BY SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **BY SECURE FAX:** 607-773-2276

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: ☐ Disability ☐ Lay Off ☐ Retired ☐ Dismissed ☐ Quit ☐ Leave ☐ Other: ______________________
Base Annual Compensation: *(As Defined in the Policy)*		

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 III | 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:

Underwritten by Renaissance Life & Health Insurance Company of America, Indianapolis, IN, and in New York by Renaissance Life & Health Insurance Company of New York. Both companies can be reached at P.O. Box 1596, Indianapolis, IN 46206. Products may not be available in all states or jurisdictions.

LIFE AND DISABILITY STATE FRAUD WARNING STATEMENTS:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW. PLEASE SEE BELOW FOR STATE-SPECIFIC VARIATIONS OF THIS FRAUD NOTICE.

CALIFORNIA: WARNING: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

FLORIDA: 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.

NEW YORK (EXCLUDING LIFE INSURANCE): 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.

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