Renaissance®
DENTAL • VISION • LIFE • DISABILITY

APPLICATION TO CONTINUE GROUP TERM LIFE INSURANCE COVERAGE

—Please Type Or Print Clearly In Dark Ink—

Employees and their insured dependents may be eligible to continue Group Term Life Insurance coverage if their coverage under the Employer Group Term Life Insurance Policy terminates. Employees should see the Certificate of Coverage for details regarding the right to continue coverage.

In order to continue your coverage you must complete this Application and submit it to Renaissance within the time-frame outlined in your Certificate of Coverage. Note that the first section of this Application must be completed by your Employer.

SECTION I | EMPLOYER INFORMATION (Completed by Employer/Policyholder)

Employer Name:	*Group Number:*	*Billing Class:*
Unit Name and Number:	*Policy Number(s):*	
Date Last Worked:	*Reason for Stopping Work:*	
Date Policyholder Provided Notice of Right to Continue/Convert to Employee:		

Was The Employee approved for Federal or State Family or Medical Leave? ☐ *Yes* ☐ *No*
If "Yes", dates of approved FML leave from/through:

Signed By Policyholder:	*Job Title/Occupation:*	*Date*	*Telephone (with area code):*

Attach Current Proof Of Coverage (Benefits Statement, Enrollment Form.)

SECTION II | EMPLOYEE INFORMATION (Completed by Applicant)

Full Name:	☐ *Male* ☐ *Female*	*Email:*		
		Phone:		
Address:		*City:*	*State:*	*Zip Code:*
Social Security Number:	*Date of Birth (mm/dd/yyyy):*	*Occupation:*		

Individuals Applying To Continue Coverage: ☐ *Employee* ☐ *Employee's Insured Spouse* ☐ *Employee's Insured Child*

Employee must continue coverage in order for Dependent coverage to continue.

SECTION III | COVERAGE ELECTIONS

Amount(s) Of Life Insurance In Force Prior To Termination:

Basic Life: $_____
Voluntary Life: $ _____
Dependent Life: $ _____

Amount(s) Of Life Insurance To Be Continued
(May Not Be More Than You Had In Force):
Basic Life: $_____
Voluntary Life: $ _____
Dependent Life: $ _____

SECTION IV | BENEFICIARY (Will revoke any existing beneficiary designations)

Full Name	Relationship to You	Social Security Number	Percentage

If you need more room, please request our Beneficiary form

SECTION V | EFFECTIVE DATES

The effective date of the coverage applied for will be the date of termination of your insurance under the Policy Number designated in the Employer Section on page one, but it is agreed that coverage shall not become effective until: (a) this Application has been approved by Renaissance at its Home Office; and (b) a check equal to the first premium payment has been received by Renaissance at its Home Office.

If your Application is approved, you will be billed for your first premium payment. (Subsequent premium payments will be billed to you in accordance with the premium mode selected by you.)

SECTION VI | PREMIUM MODE

Premium Modes Available: ☐ *Annually*

SECTION VII | APPLICANT CERTIFICATION

My deposit premium check for $20.00 is enclosed for the coverages selected. This check will be applied to my initial premium if my Application is approved and will be returned to me if my Application is not approved. I understand that I must pay the balance of the annual premium within 31 days after the date this Application has been approved by Renaissance.

I understand that I am applying for continuation of group life insurance under the Policy Number designated in the Employer section on page one, and that such coverage will terminate on the earlier of (a) the date following the maximum number of months shown in the Term Life Features - Continuation provision in your Certificate of Coverage or (b) the date the policy ceases. To the best of my knowledge and belief all foregoing statements and answers are true.

_____ _____
Applicant Signature Date Signed

For Renaissance Use Only:
Application Approved on: _____ to be Effective: _____ By: _____