Renaissance®
DENTAL • VISION • LIFE • DISABILITY

GROUP DISABILITY CLAIM FORM
EMPLOYER STATEMENT

-Please Print or Type in Dark Ink-

INSTRUCTIONS

This claim application requests information that is necessary for the quick and accurate administration of your employee's disability claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

SEND COMPLETED FORMS TO:

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

FOR QUESTIONS CALL US AT: 844-368-6485

EMPLOYER STATEMENT:

Employer Name:		**Policy Number:**	
Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Phone:	**Fax:**	**Email:**	
Employee Name *(Last, First, MI)*:		**Social Security Number:**	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Regularly Scheduled Hours Per Week:		**Date of Birth:**	
Date of Hire *(mm/dd/yyyy)*:	**Employee STD Effective Date** *(mm/dd/yyyy)*:	**Employee LTD Effective Date** *(mm/dd/yyyy)*:	
Occupation:	**A Job Description is Required if Employee is Out of Work More Than 6 Weeks:**		
Policy Class:			

Employee's Work Schedule: ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal

Check Regular Workdays: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

If Not at Work When Disability Began, Check Status & Provide Date:
☐ Terminated ☐ Leave of Absence ☐ Laid Off ☐ Sick Leave ☐ Vacation
☐ Resigned ☐ Other: _____ **Date** *(mm/dd/yyyy)*: _____

How Was Employee Paid *(Check Frequency and Types)***?:**
Frequency?: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly
Type(s): ☐ Hourly ☐ Salary ☐ Bonus ☐ Commission

EMPLOYER STATEMENT (CONTINUED)

Salary Prior to Date Last Worked:

Base Weekly Wages: $ _____

W-2 Earnings: $ _____

Overtime: $ _____

Commissions: $ _____

Bonus: $ _____

Date Last Salary Increase *(mm/dd/yyyy)*:

Employee Work Schedule at Time Last Worked:

Days Per Week: _____ Hours Per Week: _____

Date Last Worked *(mm/dd/yyyy)*:

Hours Worked That Day:

Has Employee Returned to Work?: ☐ Yes ☐ No If yes, Date: _____ ☐ Full Time ☐ Part Time

EMPLOYEE IS RECEIVING OR ELIGIBLE FOR:	YES /NO	IF YES, WEEKLY / MONTHLY AMOUNT	WK / MO	PROVIDER NAME/NOTES	DATE BENEFITS BEGIN (MM/DD/YYYY)	DATE THROUGH (MM/DD/YYYY)
Salary Continuation	☐ ☐	$	☐ ☐			
PTO	☐ ☐	$	☐ ☐			
Vacation/Sick	☐ ☐	$	☐ ☐			
Disability Pension	☐ ☐	$	☐ ☐			
Retirement Pension	☐ ☐	$	☐ ☐			
State Disability	☐ ☐	$	☐ ☐			
Unemployment	☐ ☐	$	☐ ☐			
Social Security	☐ ☐	$	☐ ☐			
Workers' Compensation	☐ ☐	$	☐ ☐			
Has Workers' Comp. Claim Been Filed?	☐ ☐	IF WORKERS' COMPENSATION HAS BEEN DENIED, SUBMIT COPY OF DENIAL WITH THIS CLAIM.				

Percentage of Premium Paid By Employer _____ %
(If Unanswered, 100% Employer Contribution Will Be Assumed and Applicable Taxes Will Be Withheld)

If the Employee Contributes Toward the Premium, Contributions are Made: ☐ **Pre-Tax** ☐ **Post-Tax**
(If Unanswered, Post-Tax Will Be Assumed)

Does Your Company Have a Rehire or Return to Work Policy for Disabled Employees?: ☐ Yes ☐ No

What is the Name of the Person We Should Contact if We Identify a Return to Work Option?:

Name/Address of the Employee's Medical Insurance Carrier or HMO *(provide policy or ID No.)*:

Name of Person Completing this Form:

Phone:	Fax:	Email:

The Above Statements Are True and Complete to the Best of My Knowledge:

X _____ _____

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

—State Fraud Warnings on Following Pages—

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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