Renaissance®
DENTAL • VISION • LIFE • DISABILITY

Renaissance Life & Health
Insurance Company of America
PO Box 1596, Indianapolis, IN 46206

GROUP TERM LIFE AND GROUP DISABILITY

APPLICANT HEALTH INFORMATION | EVIDENCE OF INSURABILITY

—Please Type Or Print Clearly In Dark Ink—

This form is only required if you are applying for Group Term Life Insurance and/or Disability coverage amounts over the Guaranteed Issue Limit, requesting an increase in coverage beyond the annual re-enrollment allowance (if any), applying more than 31 days after you were first eligible (a late applicant) or enrolling after having canceled coverage. Complete one form for each individual requesting coverage.

SECTION I | APPLICANT INFORMATION

Name of Employer:	**Policy Number:**
	Group Number:
Name of Employee *(Last, First, MI)*:	**Social Security Number:**
	Phone Number:
Date of Hire:	**Email Address:**
Earnings: Enter Salary Here: Per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other If other, specify: _____	☐ **Check This Box If You Consent To Receive Future Correspondence Regarding This Form Via Email**

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

Name of Applicant *(Person Applying for Coverage) (Last, First, MI)*:	**Place of Birth:**	**If Dependent, Relationship to Employee:** ☐ Spouse* ☐ Child

BELOW CHECK THE APPLICABLE BOX(ES) TO INDICATE WHY YOU ARE COMPLETING THIS EVIDENCE OF INSURABILITY.

An amount over the Guaranteed Issue Limit	☐ Life ☐ Disability *(Employee Only)*
Coverage as a late applicant *(or re-enrollment after cancellation)*	☐ Life ☐ Disability *(Employee Only)*
An increase in existing coverage	☐ Life ☐ Disability *(Employee Only)*

COVERAGE ELECTIONS

Group Term Life Insurance–Check with your Human Resources Department about coverage options available to you and evidence of insurability requirements.

	CURRENT AMOUNT IN FORCE	+	ADDITIONAL OR INITIAL AMOUNT REQUESTED	=	TOTAL AMOUNT
Employee	$ _____	+	$ _____	=	$
Spouse* *(Life Only)*	$ _____	+	$ _____	=	$
Child *(Life Only)*	$ _____	+	$ _____	=	$

SECTION II | **NOTICE OF INFORMATION PRACTICES** (PLEASE READ BEFORE COMPLETING THE HEALTH INFORMATION SECTION)

TO PROPERLY UNDERWRITE YOUR APPLICATION FOR CERTAIN INSURANCE COVERAGES, WE MUST COLLECT INFORMATION ABOUT YOU. WE DO THIS BY HAVING YOU COMPLETE THE HEALTH INFORMATION SECTION. IN ADDITION, WE MAY CONTACT SOURCES BESIDES YOURSELF FOR PERSONAL DATA ABOUT ANY PROPOSED INSURED, INCLUDING SPOUSE, EMPLOYER, MEDICAL PROFESSIONALS OR INSTITUTIONS, AND INSURANCE COMPANIES TO WHICH YOU MAY HAVE APPLIED FOR INSURANCE IN THE PAST. THE PERSONAL DATA MAY INCLUDE AGE, MEDICAL HISTORY, JOB, INCOME, HABITS AND OTHER PERSONAL CHARACTERISTIC INFORMATION.

WE KEEP YOUR DATA CONFIDENTIAL. ONLY EMPLOYEES PERFORMING BUSINESS TRANSACTIONS REGARDING YOUR COVERAGE WILL SEE YOUR DATA. IN CERTAIN CIRCUMSTANCES, WITH YOUR WRITTEN AUTHORIZATION, WE MAY PROVIDE DATA TO GOVERNMENT AGENCIES *(E.G., AN INSURANCE DEPARTMENT OF YOUR STATE),* OR ATTENDING PHYSICIANS.

YOU HAVE CERTAIN RIGHTS IN CONNECTION WITH THIS REQUEST FOR COVERAGE. YOU HAVE THE RIGHT TO FIND OUT WHAT PERSONAL INFORMATION IS CONTAINED IN RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA *(RENAISSANCE)* FILES *(MEDICAL INFORMATION MAY BE DISCLOSED ONLY TO YOUR ATTENDING PHYSICIAN)* AND TO CORRECT OR AMEND INFORMATION IN RENAISSANCE FILES.

UPON WRITTEN REQUEST, RENAISSANCE WILL FURNISH TO YOU *(OR YOUR DEPENDENT)* INFORMATION CONCERNING: THE NATURE AND SCOPE OF PERSONAL DATA IN OUR RECORDS; THE TYPES OF DISCLOSURES WHICH MAY BE MADE; AND RIGHTS OF ACCESS TO THE INFORMATION COLLECTED AND HOW SUCH INFORMATION MAY BE CORRECTED OR AMENDED.

WE WILL RESPOND TO SUCH WRITTEN REQUEST WITHIN 30 DAYS FROM THE DATE OF RECEIPT. FOR FURTHER INFORMATION ABOUT YOUR FILE OR RIGHTS, YOU MAY CONTACT RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA, PO BOX 1596, INDIANAPOLIS, IN 46202.

**This Health Information Form uses the term "Spouse" to refer to the person, either Spouse or Domestic Partner, for whom you are applying for benefits. If your Employer does not extend benefits to Domestic Partners your Domestic Partner should not complete this form.*

SECTION III | HEALTH INFORMATION SECTION (PLEASE READ PREVIOUS SECTION PRIOR TO CONTINUING)

1. Applicant: ☐ Male ☐ Female Height: _____ Weight: _____ Date of Birth *(mm/dd/yyyy)*: _____

2. In the last 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any ailment or injury of the following organs, diseases or disorders below?

A. High blood pressure, heart disease/disorder or chest pain?	☐ Yes	☐ No
B. Cancer, Hodgkin's disease, lymphoma or tumor?	☐ Yes	☐ No
C. Diabetes, thyroid or endocrine disorder?	☐ Yes	☐ No
D. Back, neck, joint or muscle disorder or injury?	☐ Yes	☐ No
E. A disorder of the stomach, intestines, liver, gallbladder or rectum *(gastrointestinal disorder)*?	☐ Yes	☐ No
F. A disorder of the kidney, bladder, prostate or reproductive organs *(genitourinary disorder)*?	☐ Yes	☐ No
G. A respiratory or lung disorder or shortness of breath?	☐ Yes	☐ No
H. A stroke or seizure?	☐ Yes	☐ No
I. Any psychiatric or mental health disorder or disease?	☐ Yes	☐ No
J. Alcohol or chemical dependency, or been convicted while driving under the influence of alcohol or drugs?	☐ Yes	☐ No
K. An immune system or blood disorder?	☐ Yes	☐ No

3. In the last 10 years, have you been diagnosed or received treatment from a member of the medical profession for acquired immune deficiency syndrome *(AIDS)*, AIDS related complex *(ARC)*, lymphadenopathy syndrome or any other immune system disorder? ☐ Yes ☐ No

4. Have you been diagnosed, treated or advised by a member of the medical profession in the last 5 years for any condition not listed above? If yes, identify the condition here: _____ ☐ Yes ☐ No

_____

5. In the last 5 years have you *(except those related to the Human Immunodeficiency Virus (AIDS virus))*

A. Applied for insurance which was declined, postponed, modified, rated, canceled or denied renewal?	☐ Yes	☐ No
B. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐ Yes	☐ No
C. Taken prescription medication or been under treatment or observation by a medical practitioner?	☐ Yes	☐ No

6. Are you currently able to perform all the duties of your regular occupation, or if not employed, the duties of a person of like sex and age? ☐ Yes ☐ No

7. Are you now pregnant? If yes, anticipated delivery date *(Mo/Yr)* _____ ☐ Yes ☐ No

FOR ANY "YES" ANSWERS TO QUESTIONS 2-7, PROVIDE FULL DETAILS BELOW. YOU MAY OFFER ANY ADDITIONAL EXPLANATION YOU FEEL NECESSARY.

QUESTION # AND LETTER	SPECIFY ILLNESS OR CONDITION. INCLUDE DOCTOR'S ADVICE, TREATMENT, AND MEDICATION.	DATE CONDITION BEGAN MONTH/YEAR	TIME LOST FROM NORMAL ACTIVITIES	FULL RECOVERY (IF APPLICABLE) MONTH/YEAR

SECTION IV | AUTHORIZATION AND ACKNOWLEDGMENTS

By my signature below:

I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge and belief. They are a part of a request for coverage under the group policies and will be used by Renaissance to determine insurability.

I have read, or had read to me, the questions and responses and realize any false statements, omissions and/or material misrepresentation regarding age or health information could cause coverages, if issued, to be canceled as never effective.

For the purpose of evaluating my application for insurance, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, MIB, Inc. *(formerly known as Medical Information Bureau)*, any prescription data base service; my employer; and consumer reporting agency or insurance company that has any records or knowledge of me or my health, to furnish such information to Renaissance, its employees, reinsurer(s), administrative services provider and any other authorized representative upon presenting this authorization.

This authorization includes information about mental illness and the use of drugs, alcohol or tobacco *(excluding psychotherapy notes)*; prescription drug information; sexually transmitted disease; Human Immunodeficiency Virus *(HIV)* infection ; Acquired Immune Deficiency Syndrome *(AIDS)*; and the diagnosis, treatment or prognosis of any physical condition.

I understand that:

1. This authorization may be required in order for my application for insurance to be evaluated and approved;
2. This authorization will be valid from the date signed for a period of 24 months.
3. A photographic copy of this authorization shall be as valid as the original;
4. Any request that I have made to restrict information disclosed does not apply to this authorization. I instruct the providers and entities listed in the first paragraph of this authorization to release and disclose my entire medical record without restriction;
5. The information disclosed under this authorization will be used and may be subsequently disclosed by Renaissance to: (a) underwrite and rate my application for insurance and make eligibility and enrollment determinations; (b) obtain reinsurance ; (c) process other transactions related to my policy; and (d) conduct other legally permissible or required activities that relate to any coverage I have or have applied for with Renaissance;
6. Blood, urine, saliva, or other medical tests may be required to determine insurability.
7. I may obtain a copy of this authorization form by sending a written request to Renaissance at the above address;
8. I may revoke this authorization at any time by sending a written request to Renaissance at the above address, but revocation will not affect information that has already been collected and relied upon or disclosed under this authorization; and
9. The information disclosed to Renaissance pursuant to authorization may be subject to re-disclosure with this authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act *(HIPAA)*, and therefore release of information to Renaissance is not protected under the Act. I further authorize Renaissance , or its reinsurers , to make a brief report of my protected health information to MIB, Inc.
10. My treatment, or payment for my treatment, cannot be conditioned on the signing of this authorization. However, if I refuse to sign this authorization Renaissance may not be able to process my application for insurance, or if coverage has been issued may not be able to make any benefit payments.

The insurance requested with this Evidence of Insurability form will not be effective until approved by the Home Office of Renaissance. I hereby certify that I have received a copy of this form.

FRAUD WARNING: 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.

Signature of Employee *(Required)*: X_____ Date: _____

Signature of Applicant *(Required if at least 18 years of age)*: X_____ Date: _____

FOR RENAISSANCE USE ONLY

☐ Approved ☐ Denied By: _____ Date: _____