Renaissance®
DENTAL • VISION • LIFE • DISABILITY

FOR QUESTIONS: 844-368-6485

AUTHORIZATION FOR DIRECT DEPOSIT OF PAYMENT

—Retain A Copy Of This Completed Agreement For Your Records—

SECTION A | INSTRUCTIONS

Please complete sections B, C and D and return this Authorization for Direct Deposit of Claim Payment form along with a **DEPOSIT SLIP OR VOIDED CHECK** to Renaissance Life & Health Insurance Company of America (Renaissance) at the following email address: **groupclaims@renaissancefamily.com**. Please allow up to 10 days for processing.

SECTION B | CLAIMANT INFORMATION

Full Legal Name: _____

Last 4 of SSN: _____ Phone: _____

Mailing Address: _____ Suite/Apt #: _____

City: _____ County: _____ State: _____ ZIP Code: _____

SECTION C | BANK OR FINANCIAL INSTITUTION INFORMATION (please attach a voided check)

Check One: ☐ New Account ☐ Account Change ☐ Cancel Direct Deposit

Name as it appears on Account (checking or savings): _____

Bank or Financial Institution Name: _____ Phone: _____

Address: _____ City: _____

County: _____ State: _____ ZIP Code: _____

Routing #: _____

Account #: ☐ Savings: _____ (attach deposit slip) ☐ Checking: _____ (attach voided check)

SECTION D | AUTHORIZATION STATEMENT

BY SIGNING BELOW, I REQUEST AND AUTHORIZE RENAISSANCE STATED IN SECTION A TO DEPOSIT CLAIM PAYMENT(S) AUTOMATICALLY TO THE CHECKING OR SAVINGS ACCOUNT STATED IN SECTION C. I AGREE THAT EACH DEPOSIT RENAISSANCE MAKES TO THIS ACCOUNT WILL BE A PAYMENT TO ME, WITHOUT REGARD TO THE PERSON OR PERSONS THAT MAY WITHDRAW OR RECEIVE FUNDS FROM THAT ACCOUNT. I UNDERSTAND THAT I HAVE THE OPPORTUNITY TO VIEW MY EOBS AND PAYMENT HISTORY VIA REGISTRATION ON MYRENBENEFITSMANAGER.COM OR BY CONTACTING RENAISSANCE. IN ADDITION, IF ANY OVERPAYMENT OF SUCH BENEFITS IS CREDITED TO MY BANK ACCOUNT IN ERROR, I AUTHORIZE RENAISSANCE TO WITHDRAW ANY PAYMENTS NECESSARY IN ORDER TO ASSURE THE ACCURACY OF MY CLAIM PAYMENTS. I UNDERSTAND I WILL BE ADVISED IN ADVANCE OF ANY OVERPAYMENT CORRECTION. THIS AUTHORITY WILL REMAIN IN EFFECT UNTIL I HAVE CANCELED IT IN WRITING.

AUTHORIZED ACCOUNT HOLDER

Full Legal Name, Printed: _____

Signature: X _____ Date Signed: _____