Renaissance
DENTAL • VISION • LIFE • DISABILITY

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

NEW JERSEY FLB CLAIM FORM

DIVISION OF TEMPORARY DISABILITY INSURANCE APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS (FL-1)

PLEASE DETACH THIS PAGE AND KEEP FOR YOUR RECORDS

RULES FOR FILING A CLAIM AND APPEAL RIGHTS

1. It is **your** responsibility to file this claim form promptly **after** you stop working and begin your family leave. **Filing your claim before your last day of work will delay its processing.** The law requires that claims must be filed within 30 days after the beginning of the family leave. Benefits may be denied or reduced if the claim is filed late. If your claim is filed beyond the 30-day period, please use the space provided on the reverse side of Part A to give your reasons for the late filing. **If you are receiving temporary disability benefits from the State Plan for a pregnancy related disability, you will receive instructions for claiming Family Leave benefits for bonding with your newborn child.**

2. Your signature certifies that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law. This includes any changes to the care recipient's Medical Certificate or the Employer's Statement made by you without authorization by the care recipient's physician or your employer.

3. You must inform us of any other payments you are receiving such as paid time off, a pension from your most recent employer, Workers' Compensation benefits, Social Security Disability benefits, disability benefits from your employer or union or Unemployment Insurance benefits.

4. If you receive a Family Leave Insurance Continued Claim Certification (Form FL3), it must be completed before further benefits can be authorized. Follow the instructions provided on the form and return it promptly.

5. If you return to work during the period for which you claimed Family Leave Insurance benefits, you must report this date immediately to the Division of Temporary Disability Insurance, at the telephone number listed below.

6. Family Leave Insurance benefits are subject to federal income tax and to federal rules that apply to the reporting of income and payment of taxes. However, these benefits are not subject to New Jersey state income tax. When you file your application for benefits, you can voluntarily have 10% of your benefits withheld for federal income tax. Following the end of each calendar year, you will be mailed a statement (Form 1099-G) of the total amount of benefits you received during the year. This information will also be given to the Internal Revenue Service (IRS).

7. If your home and/or mailing address changes, you must notify the Division of Temporary Disability Insurance, PO Box 387, Trenton, NJ 08625-0387 in writing. Notification must include your Social Security Number and signature. Family Leave Insurance checks cannot be forwarded by the postal service.

8. If you disagree with a determination on your claim, you may appeal. Instructions for filing an appeal will appear on your Notice of Determination.

Claim Assistance:

If you require any assistance with your claim, call Customer Service at: **844-368-6485.**

IMPORTANT: Please allow fourteen (14) days processing time before inquiring about your claim.

Email: **groupclaims@renaissancefamily.com**

Fax: **607-773-2276**

READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING THE ATTACHED APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS

A Family Leave Insurance claim can be filed when you:
Care for a seriously ill Family Member as supported by a certification provided by a health care provider. Claims may be filed for twelve consecutive weeks, for intermittent weeks or for 56 intermittent days during the 12-month period beginning with the first date of the claim.

OR

Bond with a new born or newly adopted child during the first 12 months after the child's birth or adoption. Bonding leave must be for a single continuous period of time unless the employer permits the leave to be taken in non-consecutive periods. In this case, each leave period must be at least seven days.

Requirements for taking Intermittent Leave

If your claim is for intermittent leave, you **must complete** Part E of this form, Intermittent Family Leave Schedule. The schedule must include the dates that you have been absent from work to care for a Family Member or bond with a newborn or newly adopted child. Be sure to include your name and social security number on the schedule. In order to prevent overpayment, no benefits can be authorized beyond the date of your employer's signature. Family Leave Insurance may only be claimed for whole days of leave. Benefits will not be paid for partial days of leave.

Instructions

Complete both sides of the claimant's portion of this form (Part A) making sure to:

- Include your full name and complete address.
- Print or type all information clearly. Illegible information will cause a delay in processing.
- List exact dates.
- Be sure that your social security number appears on all attachments.
- Sign your application.

1. If you are claiming benefits because you are bonding with a child, you must complete Part B and have Part D completed by your employer. Do not complete Part C.
2. If you are claiming benefits because you are caring for a seriously ill Family Member, you are responsible for having Part C completed by the care recipient and the care recipient's health care provider and Part D completed by your employer. Do not complete Part B.
3. If you have worked for more than one employer during the past year, you may copy Part D for completion by the other employer(s) to avoid processing delays. **Any missing or incorrect entries on this form will delay processing of your claim.** If you cannot have the entire application completed timely, complete Part A and submit the application as soon as possible.
4. Read all questions carefully! Print or write clearly since this information is used to determine your right to benefits. If you need any assistance in completing this form, please call **844-368-6485**.
5. **BE SURE TO WRITE YOUR SOCIAL SECURITY NUMBER, NAME, ADDRESS AND TELEPHONE NUMBER ON EACH PORTION OF YOUR CLAIM.**

Important: We suggest that you keep a copy of the completed claim form for your records.

SENDING IN SEPARATE PARTS OF THE APPLICATION WILL DELAY YOUR CLAIM. NOTE: IF YOU CHOOSE TO FAX THIS FORM TO OUR OFFICE, BE SURE TO FAX BOTH SIDES OF EACH PAGE. MAIL OR FAX PARTS A, B, C, D and E TOGETHER TO:

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

BY SECURE FAX: 607-773 -2276

BY SECURE EMAIL: groupclaims@renaissancefamily.com

FL-1

STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF TEMPORARY DISABILITY INSURANCE

APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS

PART A — TO BE COMPLETED BY THE CARE OR BONDING PROVIDER - Print or Type

FL-1(R-1-16)

1. **Name**: Last First Middle | 2. **Birth Date** | 3. **Social Security Number**

4. **Home Address – required** (Street, Apt #, City, State, Zip Code) | 5. County

6. **Mailing Address – if different** (Street, Apt #, City State, Zip Code) | 7. Male ☐ Female ☐ | 8. Occupation

9. Are you a citizen of the United States? Yes ☐ No ☐
If no, answer #10 & 11 and give country of origin: _____ | 10. Alien Reg. No. | 11. Work Authorization From _____ To _____

12. What was the last day that you worked? _____ (Month Day Year)

13. Date you want your Family Leave Insurance claim to begin:
(Include Saturday, Sunday, or Holiday.) **If this date is in the future or if this date is left blank, this application will be returned to you.** _____ (Month Day Year)

14. Reason for family leave: ☐ Care of Family Member ☐ Bond With Child

15. Will your family leave be taken on an intermittent basis? ☐Yes ☐No. **NOTE:** To claim benefits for intermittent family leave you must complete the Intermittent Family Leave Schedule, Part E, of this form (see instruction page for required information). If the intermittent leave is to bond with a newborn or newly adopted child, your employer must approve the schedule and the leave must be taken in increments of at least seven consecutive days.

16. Date you returned to work or will return to work: _____ (Month Day Year)

17. Person For Whom You Are Caring/Bonding:

Last_____ First _____ Middle_____

Street _____ City_____ State _____ Zip_____

Telephone No:_____ Date of Birth ____|____|____ Gender: ☐ Male ☐ Female

18. The Care Recipient is your: ☐ Child ☐ Spouse/ Civil Union Partner/ Domestic Partner ☐Parent ☐ Other: _____

Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If needed, space to list additional employers can be found on the reverse side of Part E.

19a. Name and address of your most recent employer:

_____

_____
(Street) (City) (State) (Zip)

Period of employment: From _____ To _____
month/day/year month/day/year

Work Telephone: _____ Location _____
City State

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division_____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

19b. Name and address of additional employer:

_____

_____
(Street) (City) (State) (Zip)

Period of employment: From _____ To _____
month/day/year month/day/year

Work Telephone: _____ Location _____
City State

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division_____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

19c. Name and address of additional employer:

_____

_____
(Street) (City) (State) (Zip)

Period of employment: From _____ To _____
month/day/year month/day/year

Work Telephone: _____ Location _____
City State

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division_____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

FL-1 (R-1-16)

Claimant's Name: _____

Claimant's Address:_____

Claimant's Telephone No:(_____)_____

Social Security Number

| | |

PART A
Continued

MUST BE COMPLETED AND SIGNED BY THE CARE/BONDING PROVIDER

20. **Have you received Family Leave Insurance benefits in the last 18 months?** Yes ☐ No ☐

21. **You must answer each question listed below for the period of family leave covered by this claim:**
   a. Did you or will you receive paid time off from your employer? Yes ☐ No ☐
   b. Have you been involved in a labor dispute (strike, lockout, etc.)? Yes ☐ No ☐

22. **Since your last day of work have you received or applied for any of the following? If yes, please list dates in the space provided.**

a. Federal Social Security Disability Benefits? Yes ☐ No ☐
b. Pension benefits from your most recent employer? Yes ☐ No ☐
c. Disability benefits provided by your employer or union? Yes ☐ No ☐
d. Unemployment Insurance Benefits? Yes ☐ No ☐
e. Worker's Compensation Benefits? Yes ☐ No ☐

Date benefit began:_____ Date benefit will end:_____

23. **Do you wish to have 10% of your benefits withheld for federal income tax?** ☐ Yes ☐ No

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION FOR QUESTIONS ON PART A

_____

_____

_____

_____

_____

If more space is needed, attach an additional sheet of paper. Be sure your Social Security Number appears on all pages.

Certification and Signature I claim Family Leave Insurance benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient identified in Part A. I hereby certify that I have read and understand my benefit rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution. You are hereby authorized to verify my Social Security Account Number, and obtain any medical, employment and other benefit entitlement information that is necessary to determine my eligibility for benefits.

Signature of Claimant_____Date_____

Witness signature if claimant writes an "X" _____

Phone No. (_____)_____ Cell Phone No. (____)_____

E-Mail Address _____

Note: The Division of Temporary Disability Insurance is not a "covered entity" under the Federal Health Information Portability & Accountability Act (HIPAA). All medical records of the Division, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law are confidential & are not open to public inspection. The Division protects all records that may reveal the identity of the claimant, or the nature or cause of the disability/family leave and the records may only be used in proceedings arising under the Law.

FL-1(R-1-16)

Claimant's Name: _____

Claimant's Address: _____

Claimant's Telephone No:(_____) _____

Social Security Number

| |

BONDING CERTIFICATION

Part B

To be completed by the person claiming Family Leave Insurance benefits to bond with a newborn or newly adopted child. NOTE: Benefits are not payable for bonding with a foster child.

DO NOT complete this portion of the application if the reason for this Family Leave Insurance benefits claim is to care for a sick Family Member. Complete Part C on the reverse side if your claim is for care giving.

DO NOT use this claim form if you are filing for Family Leave Insurance benefits to bond with your newborn child immediately after your claim for State Plan Temporary Disability or Disability During Unemployment ends. Instructions for filing a transitional bonding claim will be sent to you by the Division of Temporary Disability Insurance.

1. Legal Name of Child:

_____
(Last) (First) (Middle)

2. Child's Soc. Sec No. (If available)

| |

3. Child named in item 1 above is my:

- ☐ Child
- ☐ Adopted Child
- ☐ Domestic or Civil Union Partner's newborn or newly adopted child

4. Child's Date of Birth

_____|_____|_____
(Month) (Day) (Year)

5. Date of Adoption

_____|_____|_____
(Month) (Day) (Year)

6. Gender

- ☐ Male
- ☐ Female

7. As evidence of the relationship in Item 3, check one of the following and **attach a copy** of the document checked. The document that you submit must show your name and your child's name. **(Do not send original document, it will not be returned.)**

- ☐ Child's Birth Certificate
- ☐ Birth Mother May Submit Child's Hospital Discharge Record
- ☐ Declaration of Paternity
- ☐ Certificate of Placement for Adoption
- ☐ Independent Adoption Placement Agreement
- ☐ Other_____

8. Have you provided your employer with at least 30 days notice that you would be taking this leave? ☐ Yes ☐ No

9. **Declaration and Signature:** I authorize the medical provider, adoption agency or adoption party to disclose to the New Jersey Division of Temporary Disability Insurance all facts concerning the birth or adoption of the above-named child. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution.

Signature of Claimant_____ Date _____

Renaissance
DENTAL • VISION • LIFE • DISABILITY

FL-1(R-1-16)

Care Provider's Name: _____

Care Provider's Address: _____

Care Provider's Telephone No:(_____)_____

Care Provider's Social Security Number

| | |

PART C

Page 4 of 8

CARE RECIPIENT'S RELEASE OF MEDICAL INFORMATION

Must be signed by the care recipient or the care recipient's authorized representative.

DO NOT complete this portion of the application if the reason for this Family Leave Insurance benefits claim is to bond with a child. Complete Part B on the reverse side if your claim is for bonding.

1. Care Recipient's Name:

_____
(Last) (First) (Middle)

2. Care Recipient's Social Security Number

| | |

3. Care Recipient's Medical Disclosure Authorization and Confirmation

I authorize my physicians/health care providers to disclose my current personal health information to my care provider, identified above and to the New Jersey Division of Temporary Disability Insurance. I make this authorization to support my care provider's claim for Family Leave Insurance benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent the Division of Temporary Disability Insurance's recovery of money to which it is legally entitled. I further understand that copies of my signature below are as valid as the original.

Note: The Division of Temporary Disability Insurance is not a "covered entity" under the Federal Health Information Portability & Accountability Act (HIPAA). All of your medical records, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law are confidential & are not open to public inspection. The Division also protects all records that may reveal your identity or the identity of your care provider.

Care Recipient's Signature _____ Date_____

Witness signature if care recipient writes an "X"_____

If unable to sign, Item 4 below must be completed.

4. Authorized representative signing on behalf of care recipient must complete the following:

I, _____, represent the care recipient in this matter and I am authorized by
(print name)

☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) to do so.

Representative's Signature _____ Date_____Phone No._____

MEDICAL CERTIFICATE - To be completed by the care recipient's physician or health care provider

1. Does your patient require full time care? ☐ Yes ☐ No If no, how many days per week does your patient require care? _____

1a. What type of care can be provided to your patient by the Family Member submitting this claim?

_____
(Example: ADL's, emotional support, transportation, visitation, etc)

1b. Check here ☐ if the Family Member is unable to provide any type of care for this patient

2. Date patient's condition commenced:	3. First date care is needed:	4. Date you estimate patient will no longer require care by the care provider:	5. Date you expect patient to recover:
____|____|____	____|____|____	____|____|____	____|____|____
Month Day Year	Month Day Year	Month Day Year	Month Day Year

6. Diagnosis: (nature and cause of the condition which requires care from care provider)_____

_____ **ICD Code**: _____

7. I certify that the above statements, in my opinion, truly describes the patient's condition and need for care and the estimated duration thereof:

_____ _____ _____
(Print Name and Degree) (Original Signature Required) (Date Signed)

_____ _____
(Address) (Certificate License No. and State)

_____ _____
(City) (State) (Zip Code) (Specialty of Treating Physician)

If Resident, check ☐ Telephone Number: ( )_____ FAX No. ( )_____

Claimant's Name: _____ **Clt's Tele #(____)**_____

Clt's Address:_____

SOCIAL SECURITY NUMBER
| |

PART D

EMPLOYER'S STATEMENT - SECTION 1
TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE

FL-1(R-1-16)

1. EMPLOYER STATUS
What is your Federal Employer Identification Number: _____
Payroll number (For N.J. State Employers) _____

2. PRIVATE PLAN COVERAGE (NJ approved plan/replaces State Plan coverage)
a. Do you have a N.J. approved Private Plan for family leave? ☐Yes ☐No
b. If yes, is claimant covered? ☐Yes ☐No

3. PRIVATE PLAN TEMPORARY DISABILITY BENEFITS
a. Do you have an approved private plan for temporary disability benefits? ☐ Yes ☐ No If yes, please provide the following:
1. Did the claimant collect benefits from your approved private plan immediately prior to the family leave? ☐ Yes ☐ No
2. If known, provide the dates and Weekly Benefits Rate that your private plan paid temporary disability benefits:

From ____|____|____ through ____|____|____ Weekly Benefit Rate $_____
Month Day Year Month Day Year

4. LAST ACTUAL DAY WORKED before the family leave
(do not use payroll week ending dates) ____|____|____
Month Day Year

a. Is the separation permanent? ☐ Yes ☐ No Reason for separation: _____

b. Has claimant returned to work? ☐ Yes ☐ No If yes, give date ____|____|____
Month Day Year

5. ENTITLEMENT REDUCTION OPTION (do not enter dates prior to family leave)
a. Do you want to reduce the employee's maximum entitlement up to two (2) weeks if the employee is required to use paid time off (vacation, sick, personal, etc)? ☐Yes ☐ No

b. If yes, provide the dates and the number of full days the employee is required to use.

From ____|____|____To ____|____|____ Number of Days _____
Month Day Year Month Day Year

6. OTHER PAID TIME OFF
a. Is the employee receiving or will he/she receive any paid time off not included in (5b.) above. ☐ Yes ☐No If yes, please provide the following.

Dates Paid : From ____|____|____ To____|____|____
Month Day Year Month Day Year

Amount per week $_____, if amount or dates vary attach a list for each time period.
b. Check the number that best describes the monies paid in item a. **Note:** Items 3 and 4 will not affect the benefits.
☐ 1. Paid Time Off (Vacation, Sick, Personal, etc)
☐ 2. Pension
☐ 3. Supplemental benefits or gratuities
☐ 4. Difference between regular weekly wage and Family Leave Insurance benefits to be received or full salary advanced to effect the difference.

7. LEAVE INFORMATION
a. Did your employee provide you with reasonable and practicable notice of this period of family leave? ☐ Yes ☐ No If no, attach explanation.
b. Is the employee taking this leave on an intermittent basis? ☐Yes ☐No
c. If yes, have you agreed to the intermittent schedule? ☐Yes ☐No

8. OTHER BENEFITS
Has the claimant filed for or received:
a. Workers' Compensation Benefits ☐ Yes ☐ No
b. Sick Leave Injury (gov't workers only) ☐ Yes ☐ No
c. Unemployment Benefits ☐ Yes ☐ No

9. Check the days of the week the employee normally works.
SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

PLEASE BE SURE TO COMPLETE AND SIGN SECTION 2 ON THE REVERSE SIDE OF THIS PAGE

Claimant's Name: _____ **Clt's Tele #(____)**_____

Clt's Address:_____

SOCIAL SECURITY NUMBER
| |

PART D
Continued

EMPLOYER'S STATEMENT - SECTION 2

FL-1(R-1-16)

10. EDUCATIONAL INSTITUTIONS (complete this section)

a. Is your facility classified as an "educational institution" which is approved to operate as a school by the State Department of Education? ☐ Yes ☐ No

b. Does any part of the period claimed occur during a school wide recess, vacation period or between academic terms? ☐ Yes ☐ No
If yes, list the dates: Beginning Date_____ Date School Resumes _____

11. BASE WEEKS AND BASE YEAR GROSS WAGES

A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of $220 or more **OR** any week (up to 13 weeks) in which the claimant is separated from employment due to a declared state of emergency during the base year.

The BASE YEAR is the 52 calendar weeks preceding the week in which the family leave began. If the claimant collected temporary disability benefits from either the State Plan or a Private Plan immediately prior to the family leave, the base year is the 52 weeks prior to the beginning of the temporary disability claim.

a. Total Number of **Base Weeks** _____
b. Total **Gross Wages in Base Year** _____
(Include all wages earned by the claimant)

12. REGULAR WEEKLY WAGE $ _____

13. Weekly wages

Indicate below: dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks. If the claimant collected temporary disability benefits from either the State Plan or a Private Plan immediately prior to the family leave, list the weekly wages prior to the beginning of the temporary disability claim.

Description of Calendar Week	Calendar Week Ending Date	Gross Wages	Description of Calendar Week	Calendar Week Ending Date	Gross Wages
Week Family Leave Began		$	6th Week Before Family Leave		$
Week Before Family Leave		$	7th Week Before Family Leave		$
2nd Week Before Family Leave		$	8th Week Before Family Leave		$
3rd Week Before Family Leave		$	9th Week Before Family Leave		$
4th Week Before Family Leave		$	10th Week Before Family Leave		$
5th Week Before Family Leave		$	**Total Gross Wages for these Weeks**		$

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name _____

Address _____

City, State, Zip_____ Print or Type Name _____

Signature_____ Date_____

Mailing Address, if different_____ Official Title_____

FAX No. ( ) _____ Phone No. ( ) _____E-Mail Address_____

Renaissance®
DENTAL • VISION • LIFE • DISABILITY

Claimant's Name: ______________________ Clt's Tele #(____)__________ Clt's Address: ______________________________	SOCIAL SECURITY NUMBER | |

PART E — **INTERMITTENT FAMILY LEAVE CLAIM**

 FL-1(R-1-16)

Instructions: This form must be completed if you are filing a claim for intermittent Family Leave Insurance. Family Leave Insurance may only be claimed for whole days of leave. Benefits will not be paid for partial days of leave. Additionally, in order to prevent overpayment, no benefits will be authorized beyond the date of your employer's signature.

1. Indicate the start date of the week you are claiming intermittent leave beginning with Sunday. If more space is required, attach an additional list to the application. Be sure it includes your social security number.
2. Check the day(s) that you have been absent from work to care for a Family Member or bond with a newborn or newly adopted child. Claims for bonding must be in increments of at least seven consecutive days.
3. An authorized employer representative must sign below confirming the dates you have entered.

Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ____________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

Firm Name: ________________________________ Telephone No: ______________

Employer's Representative: ____________________________ Date: ______________
(print or type name)

Signature of Employer's Representative: ________________________________

Renaissance®
DENTAL • VISION • LIFE • DISABILITY

Claimant's Name: _____Clt's Tele #(____)_____ Clt's Address:_____ Page 8 of 8	SOCIAL SECURITY NUMBER | |

Fl-1(R-1-16)

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION

If more space is needed, attach an additional sheet of paper. Be sure your Social Security Number appears on all pages.