Renaissance®
DENTAL • VISION • LIFE • DISABILITY

FOR QUESTIONS: 844-368-6485

GROUP DISABILITY CLAIM FORM

SUPPLEMENTARY STATEMENT

—Please Type Or Print Clearly In Dark Ink—

INSTRUCTIONS:

THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE, EMPLOYER AND THE ATTENDING PHYSICIAN OR HEALTH CARE PROVIDER. TO AVOID DELAY, PLEASE RETURN THE COMPLETED FORM PROMPTLY. FOR QUESTIONS CALL 844-368-6485.

SEND FULLY COMPLETED FORM TO RENAISSANCE GROUP CLAIMS AT:

- **BY SECURE EMAIL:** groupclaims@renaissancefamily.com
- **BY MAIL:** PO Box 1596 Indianapolis, IN 46206
- **BY FAX:** 607-773-2276

SECTION I | TO BE COMPLETED BY EMPLOYEE

Full Name *(Last, First, MI)*:	**Claim Number:**

Street Address *(Include Apt#/Suite)*: ***Please Check if Address has Changed*** ☐	**City:**	**State:**	**ZIP Code:**

Has Your Doctor Discharged You From Care for this Disability? ◯ Yes ◯ No **If Yes, Give Date** *(mm/dd/yyyy)*:

If No, Date of Next Appointment *(mm/dd/yyyy)*:

Has Your Disability Ended? ◯ Yes ◯ No **If yes, Give Date** *(mm/dd/yyyy)*:

Date You Returned to Work *(mm/dd/yyyy)*: ◯ Full-Time ◯ Part-Time	**OR if Still Disabled, Expected Date of Return** *(mm/dd/yyyy)*: ◯ Full-Time ◯ Part-Time

Describe Your Present Daily Activities:

Are You Attending Physical Therapy? ◯ Yes ◯ No	**Are You Participating in a Rehabilitation Program?** ◯ Yes ◯ No

Employee Signature *(Required)*: X _____ **Date Signed** *(mm/dd/yyyy)*: _____

SECTION II | EMPLOYER STATEMENT

Has Employee Returned to Work? ◯ Yes ◯ No If Yes, Give Date *(mm/dd/yyyy)*:	If No, What Date is the Employee Expected to Return to Work *(mm/dd/yyyy)*:

If Not Returning, When Was This Employee Terminated *(mm/dd/yyyy)*?
Did Employee Receive Any Payments as Part of a Termination OR Severance Agreement ◯ Yes $_____ ◯ No

Name of Person Completing This Section *(Last, First, MI)*:	Title:

Employer Signature *(Required)*: X_____ Date Signed *(mm/dd/yyyy)*: _____

SECTION III | ATTENDING PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER STATEMENT

Patient's Name *(Last, First, MI)*:	Date of Next Scheduled Appointment *(mm/dd/yyyy)*:

Nature of Sickness or Injuries:

If Disability is Caused by Pregnancy, Indicate Delivery Date *(mm/dd/yyyy)*:

Type of Delivery:

Date of First Treatment *(mm/dd/yyyy)*:	Date of Most Recent Treatment* *(mm/dd/yyyy)*:
Frequency of Treatments *(mm/dd/yyyy)*:	Date of Surgery *(mm/dd/yyyy)*:

Nature of Surgery/Treatment:

Date of Final Discharge *(mm/dd/yyyy)*:	Dates of Total Disability *(mm/dd/yyyy)*: From:_____ Through:_____	Dates of Partial Disability *(mm/dd/yyyy)*: From:_____Through:_____

Date Patient Able to Return to Work *(mm/dd/yyyy)*: ◯ Full-Time ◯ Part-Time Hours Per Day: _____

Complications Or Other Factors Delaying Recovery?

Restrictions, Limitations and Prognosis for Return to Work *(Failure to Provide this Information May Delay Future Benefits)*:

Name of Attending Physician, Physician Assistant, or Nurse Practitioner :	License Number:		
	Phone:		
Street Address *(Include Apt#/Suite)*:	City:	State:	ZIP Code:

X_____ _____
Signature of Attending Physician, Physician Assistant, or Nurse Practitioner 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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