Renaissance®
DENTAL • VISION • LIFE • DISABILITY

CALIFORNIA

PO Box 1596 Indianapolis, IN 46206

GROUP ACCELERATED DEATH BENEFITS APPLICATION & CLAIM FORM

—Please Type or Print Clearly in Dark Ink—

INSTRUCTIONS

☐ **THERE ARE FOUR (4) PRIMARY SECTIONS TO BE COMPLETED IN THIS FORM. ALL SECTIONS MUST BE SIGNED AND DATED:**

- SECTION 1: Disclosure Statements and Application to Accelerate Benefits
- SECTION 2: Claimant Statement
- SECTION 3: Employer or Plan Administrator Statement
- SECTION 4: Attending Physician, Physician's Assistant, Nurse Practitioner Statement

☐ **SEND COMPLETED FORM TO RENAISSANCE GROUP CLAIMS:**

- BY MAIL: PO Box 1596 Indianapolis, IN 46206

OR

- BY SECURE FAX: 607-773-2276
- BY SECURE EMAIL: groupclaims@renaissancefamily.com

☐ **HAVE QUESTIONS OR NEED ASSISTANCE COMPLETING THIS FORM?**

- CONTACT CLAIMS AT: 844-368-6485

SECTION I | DISCLOSURE STATEMENT AND APPLICATION TO ACCELERATE BENEFITS

1. Receipt of Accelerated Death Benefits ("ADB") may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for ADB, you should consult with the appropriate social services agency concerning how receipt will affect your eligibility and/or your spouse or dependents.
2. Receipt of ADB may be taxable. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.
3. Your application for an ADB is voluntary on your part and without coercion on the part of any third party.
4. Renaissance certifies that no later than at the time of application for the accelerated death benefit, a written benefit payment notice will be provided to you. The notice will show the following: 1) the face amount of the benefit. 2) the percentage of acceleration; 3) the amount of the benefit you will receive, less the applicable discount; and 4) the remaining death benefit.

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA AND IN NEW YORK, RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF NEW YORK ("RENAISSANCE") HERBY CERTIFIES THAT ALL THE INFORMATION INCLUDED HEREIN AND IN THE BENEFIT PAYMENT NOTICE WILL BE BASED ON CONTRACT GUARANTEES.

SECTION I.A | APPLICATION TO ACCELERATE BENEFITS

IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF THE GROUP TERM LIFE INSURANCE ACCELERATED DEATH BENEFIT (ADB) COVERAGE, I HEREBY APPLY FOR AN ADB. I UNDERSTAND THAT THE REMAINING DEATH BENEFIT AVAILABLE TO MY BENEFICIARY WILL BE REDUCED BY THE AMOUNT OF THE ADB PAID AND THE APPLICABLE DISCOUNT. ALTHOUGH THERE IS NO SEPARATE IDENTIFIABLE PREMIUM ASSOCIATED WITH THE ACCELERATED PAYMENT, THERE IS A DISCOUNT ASSOCIATED WITH ACCELERATION.

TO BE VALID, THIS APPLICATION MUST BE SIGNED BY YOU, THE CERTIFICATE HOLDER, AND WITNESSED. IF THE APPLICANT WISHES TO WITHDRAW HIS OR HER ELECTION PRIOR TO THE ADB PAYMENT BEING ISSUED, HE OR SHE CAN DO SO WITHOUT PENALTY OR COST.

Date at: ________________________ This: __________ Day of: __________, __________.
(City and State) *(Day)* *(Month)* *(Year)*

Witness Printed Name *(Last, First, MI)*:	**Witness Signature** *(Required)*:
Certificate Holder Full Name *(Last, First, MI)*:	**Certificate Holder Signature** *(Required)*:

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE MISSTATED OR UNTRUE, THE INSURER MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR ACCELERATED DEATH BENEFIT COVERAGE.

SECTION I | EMPLOYEE INFORMATION

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	**Social Security Number:** **D.O.B** *(mm/dd/yyyy)*:

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

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married	Phone Number:
	Email:

Designate a third party to receive notice of lapse or termination: ____________________

Date of First Treatment *(mm/dd/yyyy)*:	**Nature of Sickness or Injuries:**
Date of Sickness or Accident *(mm/dd/yyyy)*:	
Benefit Percent Requested: __________%	
Have You Filed for Bankruptcy? ☐ Yes ☐ No	
Have You Applied for Portability? ☐ Yes ☐ No	**Have You Applied for Conversion?** ☐ Yes ☐ No

Do You Attest that Your State of Health is Such That Your Life Expectancy is Twelve Months or Less? ☐ Yes ☐ No

Is the Accelerated Death Benefit intended to replace any long term care insurance? ☐ Yes ☐ No

SECTION I.A | TREATING PHYSICIANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS:

Full Name *(Last, First, MI)*:		**Date of First Treatment** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Full Name *(Last, First, MI)*:		**Date of First Treatment** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Full Name *(Last, First, MI)*:		**Date of First Treatment** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

SECTION I.B | HOSPITALS:

Hospital Name:		**Date Admitted** *(mm/dd/yyyy)*: **Date Discharged** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Hospital Name:		**Date Admitted** *(mm/dd/yyyy)*: **Date Discharged** *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SECTION I.B | APPLICANT AUTHORIZATION

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY, THE MIB, INC., 791.06(C) WHO HAS ATTENDED ME OR HAS ANY RECORDS OR KNOWLEDGE OF ME OR MY HEALTH TO FURNISH RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA AND RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF NEW YORK OR THEIR REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATIONS, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL AND MEDICAL RECORDS. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT, MAY BE TAXABLE, AND MAY AFFECT ELIGIBILITY FOR TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. ASSISTANCE FROM A TAX ADVISOR IS RECOMMENDED.

Date at: ______________________________ This: __________ Day of: __________, __________.
(City and State) *(Day)* *(Month)* *(Year)*

Applicant Signature *(Required)*:

SECTION II | EMPLOYER OR PLAN ADMINISTRATOR STATEMENT

Employer Name: | **Policy Number:**

Street Address *(Include Suite)*: | **City:** | **State:** | **ZIP Code:**

Phone: | **Email:** | **Fax Number:**

Employee Name *(Last, First, MI)*: | **Classification:**

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

Employee Social Security Number: | **Job Title/Occupation:**

Date of Employment *(mm/dd/yyyy)*: | **Effective Date of Employee's Insurance** *(mm/dd/yyyy)*:

Base Annual Compensation *(As Defined in the Policy)*:
$ __________

Amount of Insurance on Last Day of Active Employment:
$ __________

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

Reason for Leaving Work: ☐ Disability ☐ Lay Off ☐ Dismissed ☐ Quit ☐ Leave ☐ Retired ☐ Other______________________

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED ON THE NAMED EMPLOYEE IS ACCURATE.

Date at: ______________________________ This: __________ Day of: __________, __________.
(City and State) *(Day)* *(Month)* *(Year)*

Printed Name of Authorized Employer Representative: | **Authorized Employer Representative Job Title:**

Signature of Authorized Employer Representative *(Required)*:

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

Physician, Physician Assistant or Nurse Practitioner Name *(Last, First, MI)*:			**Tax ID Number:**
Street Address *(Include Suite)*:	**City:**	**State:**	**ZIP Code:**
Email:	**Fax:**		
Patient's Name *(Last, First, MI)*:			**Date of Birth** *(mm/dd/yyyy)*:
Nature of Sickness or Injuries *(Describe Complications, If Any)*:	**Date Symptoms Appeared or Date of Accident** *(mm/dd/yyyy)*:		
	Date First Consulted for This Condition *(mm/dd/yyyy)*:		

SECTION III.A | HOSPITALIZATIONS:

Hospital Name:		**Date Admitted** *(mm/dd/yyyy)*:	
		Date Discharged *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Hospital Name:		**Date Admitted** *(mm/dd/yyyy)*:	
		Date Discharged *(mm/dd/yyyy)*:	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Briefly Describe the Course of Treatment to Date:	**Additional Comments:**		

Do you attest that the patient's state of health is such that the patient's life expectancy is 12 months or less? ☐ Yes ☐ No
(Please submit documentation supporting your position)

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED ON THE NAMED EMPLOYEE IS ACCURATE.

Date at: ______________________ *(City and State)* **This:** __________ *(Day)* **Day of:** __________ *(Month)*, __________ *(Year)*.

License Number:	**License State:**

Physician, Physician Assistant or Nurse Practitioner Signature *(Required)*:

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.