Renaissance®
DENTAL • VISION • LIFE • DISABILITY

Renaissance Life & Health
Insurance Company of America

INTERMITTENT ABSENCE CLAIM FORM

-Please Print or Type in Dark Ink-

INSTRUCTIONS

- Use this form to report absence dates for payment under an approved intermittent claim.
- Only dates of absence that have already occurred are to be reported on this form. Future dates cannot be submitted.
- The form must be signed by an authorized employer representative. The signature date must be on/after the last date of absence reported on the form.
- To ensure timely processing of payments, submit the form at the end of each pay period during which intermittent absences were taken.

FOR FASTEST SERVICE, PLEASE SUBMIT THE COMPLETED FORM BY EMAIL OR FAX.

- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX:** 607-773-2276
- **MAIL:** 225 S East Street, Suite 360; Indianapolis, IN 46202

Continued on next page >>>

SECTION I | EMPLOYEE/APPLICANT INFORMATION

Claim Number:	
Employee First Name:	**Employee Last Name:**
Date of Birth (mm/dd/yyyy)**:**	**Last 4 Digits of SSN:**
Phone Number:	**Email:**

SECTION II | EMPLOYER INFORMATION

Business Name:	
Employer Representative Name:	
Contact Phone Number:	**Contact Email:**

WEEK 1

Weekday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date							
Hours							
Unpaid or Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid

WEEK 2

Weekday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date							
Hours							
Unpaid or Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid	☐ Unpaid ☐ Paid

SIGNATURES

EMPLOYEE DECLARATION AND SIGNATURE:

BY SIGNING BELOW I AGREE THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

X _____ _____

Signature of Employee **Date Signed** *(mm/dd/yyyy)*

EMPLOYER DECLARATION AND SIGNATURE:

I DECLARE I AM AUTHORIZED TO COMPLETE AND SIGN AS A REPRESENTATIVE OF THE EMPLOYER OF THE EMPLOYEE REQUESTING PFML. BY SIGNING BELOW I AGREE THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

X _____ _____

Signature of Employer's Authorized Representative **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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