Renaissance®
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GROUP DISABILITY PREGNANCY CLAIM FORM
PHYSICIAN STATEMENT

-Please Print or Type in Dark Ink-

INSTRUCTIONS:

This form requests information necessary for the quick and accurate administration of your patient's disability claim. If a question does not apply, or information is not available, please indicate "NA" (Not Applicable).

SEND COMPLETED FORMS TO:

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- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX TO:** 607-773-2276
- **MAIL:** PO Box 1596 Indianapolis, IN 46206

FOR QUESTIONS CALL US AT: 844-368-6485

CLAIM NUMBER:	POLICY NUMBER:

SECTION I | PATIENT INFORMATION

Patient Name *(Last, First, MI)*:	Date of Birth *(mm/dd/yyyy)*:

Height:	Weight:	Blood Pressure *(Last Visit)*:

Complete All The Following Items

LMP Date: *(mm/dd/yyyy)*:	EXP. Date of Delivery: *(mm/dd/yyyy)*:	Date First Treated: *(mm/dd/yyyy)*:	Date Last Treated: *(mm/dd/yyyy)*:

If taken off work prior to the delivery date, please list the complications that require the patient to stop working early:

Delivery

Actual Date of Delivery: *(mm/dd/yyyy)*:	Type of Delivery: ☐ Vaginal ☐ C-Section	Date of Hospitalization	
		Admit Date: *(mm/dd/yyyy)*:	Discharge Date: *(mm/dd/yyyy)*:

If applicable, please list any complications with the delivery:

SECTION II | PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT

Print Name of Attending Physician, Physician Assistant, or Nurse Practitioner: *(Last, First, MI)*:

Email Address:			Phone Number:
Degree/Specialty:			Fax Number:
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 Below—

Underwritten by Renaissance Life & Health Insurance Company of America, Indianapolis, IN, and in New York by Renaissance Life & Health Insurance Company of New York. Both companies may be reached at PO Box 1596, Indianapolis, IN 46206. Products may not be available in all states or jurisdictions.

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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