Renaissance

DENTAL · VISION · LIFE · DISABILITY

P.O. Box 1596, Indianapolis, IN 46206

Renaissance Life & Health Insurance Company of America

FLORIDA

RENAISSANCE EMPLOYEE ENROLLMENT FORM

—Please Type Or Print Clearly In Dark Ink—

SECTION I | EMPLOYER INFORMATION (Policyholder Use Only)

Name of Employer:	**Group ID Number:**	**Billing Class:**
Unit Name and Number:	**Policy Number(s):**	
Date of Hire or Rehire: / **Hours Worked Per Week:**	**Earnings: $** _____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other If Other Specify: _____	

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Re-enrollment ☐ Change in Status ☐ Other
If Other Specify: _____

SECTION II | EMPLOYEE INFORMATION (Completed By Applicant)

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	**Email:** / **Phone:**	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Social Security Number:	**Date of Birth** *(mm/dd/yyyy)*:	**Job Title/Occupation:**	

SECTION II.A | SPOUSE INFORMATION (If Applying For Benefits For Your Spouse*, Complete Information Below)

Your ☐ Spouse ***OR*** ☐ Domestic Partner* *(Check One Box Only)*	**Full Name** *(Last, First, MI)*:	☐ Male ☐ Female	**Date of Birth** *(mm/dd/yyyy)*:	**Social Security Number:**
Street Address *(Include Apt#/Suite)*: ☐ *Check if same as above*		**City:**	**State:**	**ZIP Code:**

SECTION II.B | CHILD(REN) INFORMATION (If Applying For Benefits For Your Dependent Child(ren), Complete Information Below)

DEPENDENT'S NAME (LAST, FIRST, MI)	MALE (M) FEMALE (F)	FULL-TIME STUDENT	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		

If more than four children are to be enrolled, include a separate list including the above information with this form

**This Employee Enrollment Form uses the term "Spouse" to refer to the person, either Spouse or Domestic Partner, for whom you are applying for benefits. If your Employer does not extend benefits to Domestic Partners and you are not enrolling a Spouse, leave this section blank.*

SECTION III | COVERAGE ELECTIONS

IF YOU SELECT "NO COVERAGE" BELOW, YOU ACKNOWLEDGE THAT YOU UNDERSTAND THAT IF YOU APPLY FOR COVERAGE AT A LATER DATE, YOU WILL BE CONSIDERED A LATE APPLICANT, YOU MAY BE SUBJECT TO WAITING PERIODS AND/OR REQUIRED TO FURNISH EVIDENCE OF INSURABILITY AT YOUR OWN EXPENSE, AND THAT RENAISSANCE WILL HAVE THE RIGHT TO REFUSE YOUR REQUEST.

A. DENTAL COVERAGE	**Plan Option** *(if choice provided)*: **Circle: HIGH or LOW Plan**	**Select One:** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ No Coverage
B. VISION COVERAGE	**Plan Option** *(if choice provided)*:	**Select One:** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ No Coverage

SECTION IV | ELECTRONIC DELIVERY OF DOCUMENTS

Electronic Delivery of Policy Document

☐ Yes, send the following information electronically: Certificate of Coverage, Summary of Benefits, ID Cards, Explanation of Benefits, Renewal Letters and related coverage and claim documents.

By checking the box above, you are agreeing to receive such materials electronically pursuant to the Terms for Paperless Delivery attached to this Employee Enrollment Form. **You must provide a current email address on the first page of this Employee Enrollment Form.** If the box is not checked, all materials will be sent by hard copy.

SECTION V | SIGNATURES

My signature on this Employee Enrollment Form further represents that:

I authorize my Employer's Payroll Department to deduct the required premium, if any, from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my Employer and Renaissance, and are to be paid to Renaissance when due.

I am applying for the coverages designated for which I am eligible under my Employer's plan with Renaissance and I understand that my dependents are not eligible for coverage if I am not enrolled.

The Employee Enrollment Form is subject to approval, refusal or modification in accordance with Renaissance guidelines. Misrepresentation or fraud will cause this form and subsequent coverage to be null and void from the start, subject to the Incontestability provision of the Certificate. 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.

Applicant Signature *(Required)*: X _____ Date: _____

SOLICITING AGENT(S)	GENERAL AGENT(S) *(If Applicable)*
Printed Name: _____	Printed Name: _____
Signature: _____ Date: _____	Signature: _____ Date: _____
FL Agent License #: _____	FL Agent License #: _____