Renaissance℠

Employer Application and Agreement

Please take a moment to complete this form. We will consider it along with your group's experience, enrollment data and any other applicable information, as your application to Renaissance Life & Health Insurance Company of America or Renaissance Health Insurance Company of New York (Renaissance).

- Coverage or administration for your group will not start until you receive approval in writing from Renaissance.
- Absence of written approval does not imply acceptance.
- There may be minimum enrollment requirements.
- Rates are subject to change based on final enrollment data and any program design changes.

If you have any questions regarding this application or Renaissance, please feel free to contact your Renaissance representative.

(Shaded areas are for Renaissance use only) Group Number ____________

Group Name ____________

Requested Effective Date ____________ Renewal Date ____________

Amount paid by Employer for: Employee Coverage ____________ Dependent Coverage ____________

Can employees opt out of dental plan? ☐ Yes ☐ No Is there a Section 125 Plan in place? ☐ Yes ☐ No

Are any classes excluded? ☐ Yes ☐ No or Is this a Management Carve-out? ☐ Yes ☐ No

If yes, explain ____________

Number of Eligible Employees ____________ Number of Employees Enrolling ____________

New Employee Waiting Period: First of the month following ____________ days

Waived at initial enrollment? ☐ Yes ☐ No

Group Address ____________

City ____________ County ____________

State ____________ Zip Code ____________

Telephone ( ) ____________ Fax Number ( ) ____________

Billing Address (if different from above) ____________

City ____________ State ____________ Zip Code ____________

Group Officer Mr. Ms. Dr. ____________ Title ____________

Group Contact Mr. Ms. Dr. ____________ Title ____________

E-Mail Address ____________ Tax Identification Number ____________

Type of Industry ____________ NAICS Code ____________

Send materials to ____________

Account Executive ____________ Industry Code ____________

Account Service Manager ____________ Underwriter ____________

Previous Carrier ☐ None ☐ Yes (indicate carrier) ____________

Enrollment by ☐ Form ☐ Electronic Media (specify) ______

Standard Materials include Certificate, Summary, and ID Cards

Other materials requested ______
(additional charges may apply)

Definition of Subscriber (for example: "All full-time employees working at least 25 hours per week.")

______

______

BENEFITS
Benefit Plan Type: ☐ Indemnity FFS ☐ Indemnity Schedule ☐ Preferred Provider (PPO)

(Please attach copy of proposal)	**Indemnity Fee For Service**	**Preferred Provider (PPO)**	
		In-Network	**Out-of-Network**
Diagnostic			
Preventive			
Bitewing Radiographs			
Space Maintainers			
Sealants			
All Other Radiographs			
Emergency Palliative			
Simple Extractions			
Minor Restorative			
Endodontics			
Periodontics			
Major Oral Surgery			
Major Restorative			
Prosthodontics			
Relines and Repairs			
Implants			
Orthodontics			
TMJ Appliances			

Annual Maximum Amount $ ______ Allowed Amount ______

Orthodontic Age Limit ☐ Standard (19) ☐ Other ______

Orthodontic Lifetime Maximum Amount $______

Deductible: $ ______ per person per year limited to a maximum of $ ______ per family per year

(check one) ☐ Calendar Year ☐ Contract Year

Deductible is Applicable to ☐ All Services ☐ All Services Except ______

Three-Month Deductible Carry-over? ☐ Yes ☐ No Deductible Credit from Prior Carrier? ☐ Yes ☐ No

VISION: Enhanced ☐ Yes ☐ No Plus Plan: ☐ Yes ☐ No

RATES PER SUBSCRIBER PER MONTH

(check one) ☐ 1 Tier ☐ 2 Tier ☐ 3 Tier ☐ 4 Tier

Tier Description

______________________________ $______________________________
______________________________ $______________________________
______________________________ $______________________________
______________________________ $______________________________

ADMINISTRATIVE SERVICES ONLY (ASO) FEES

☐ Percentage of Claims ______________________________
☐ Per Capita $ ______________________________
☐ Per Transaction $ ______________________________
☐ 1 Month Prefund $ ______________________________

Administration ________ % (use one year administration only)

History Crosscheck ____________

CONTRACT TYPE

☐ Non-Retention
☐ Administrative Services Plan
☐ Aggregate Stoploss _______ %

☐ Other ______________________________

ERISA Information Schedule A (Form 5500) required? ☐ Yes ☐ No Time Period ______________________

REPORTS REQUIRED

____
____
____

SPECIAL INSTRUCTIONS

____
____
____

AGREEMENT AND RECEIPT

The undersigned employer hereby adopts and subscribes to the terms and provisions in the application and to the terms and provisions of the contract of which this application becomes a part. It is agreed that the employer has 15 days from the date of delivery of the contract to return the contract to Renaissance's corporate headquarters for a full refund. If the employer exercises this right, the contract will terminate on the effective date as if no coverage or administrative services were ever in force, and all money received will be returned. This application is subject to approval, refusal, or modification in accordance with Renaissance's guidelines. Misrepresentation or fraud will cause this application and subsequent contract to be null and void from the start. Any person, who knowingly and with intent to injure, defraud, or deceive any insurer, or files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree. **Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.**

Check #______________ in the amount of $______________ to be applied as a credit toward the payment of the first month's premium on the proposed Renaissance program for which application is made. In case application is not accepted by Renaissance, the payment indicated here will be returned.

Signed this _______ day of ____________________, 20 ______ at ______________________________

Signature of Authorized Group Official ______________________________ Title ____________________

Signature of Agent ______________________________ Lic. # ____________________ State __________

Signature of Renaissance Representative ______________________________

Renaissance Life & Health Insurance Company of America
Renaissance Health Insurance Company of New York

FOR AGENTS ONLY

Agent Name ______________________________

Agency Name ______________________________

Agent License Number ______________________________

Street Address ______________________________

City ____________ County ____________ State ________ ZIP Code ________

Telephone (   ) ______________________ Fax number (   ) ______________________

E-Mail Address ______________________________

New Agent/Agency? ☐ Yes ☐ No If yes, attach New Agent Documentation

Commission: ☐ Standard Split: ☐ 50/50 ☐ Other (please indicate) ______________

2nd Agent Name (if applicable) ______________________________

Agency Name ______________________________

Agent License Number ______________________________

Street Address ______________________________

City ____________ County ____________ State ________ ZIP Code ________

Telephone (   ) ______________________ Fax number (   ) ______________________

E-Mail Address ______________________________

New Agent/Agency? ☐ Yes ☐ No If yes, attach New Agent Documentation

General Agent (if applicable) ______________________________