Renaissance®
DENTAL • VISION • LIFE • DISABILITY

CLAIMS SUBMISSION FOR:

☐ SHORT TERM DISABILITY ("STD")
☐ LONG TERM DISABILITY ("LTD")

GROUP DISABILITY CLAIM FORM

EMPLOYEE STATEMENT

-Please Print or Type in Dark Ink-

INSTRUCTIONS

This employee statement requests information that is necessary for the quick and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

A. THERE ARE FOUR (4) PRIMARY FORMS REQUIRED TO FILE A DISABILITY CLAIM:

- Employee Statement
- Employee Authorization (to be completed by you, the employee)
- Employer Statement
- Physician Statement

B. SEND COMPLETED FORM TO:

- **MAIL:** 2 Court St. Suite 102, Binghamton, NY 13901
- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX:** 607-773-2276

TOLL FREE TELEPHONE: 844-368-6485

C. IT IS THE RESPONSIBILITY OF YOU AND YOUR EMPLOYER TO INFORM US OF YOUR SCHEDULED OR ACTUAL RETURN TO WORK DATE AS SOON AS POSSIBLE.

D. PLEASE NOTE: IF AN OVERPAYMENT SHOULD OCCUR ON YOUR CLAIM, THE AMOUNT OF THE OVERPAYMENT MUST BE RETURNED TO US.

SECTION I | EMPLOYEE STATEMENT

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

Employer Name:

Employee's Occupation and Duties *(Please List Occupation Duties Below)*:

Date of Accident or Date of First Symptoms *(mm/dd/yyyy)*:	**Last Date Worked** *(mm/dd/yyyy)*:

You Are Unable to Work Due To *(Check One)*: Injury Illness Pregnancy

Date You Returned to Work *(mm/dd/yyyy)*: Full Time Part Time

If You Have Not Returned to Work, When Do You Expect to Return *(mm/dd/yyyy)*?: Full Time Part Time

Describe In Detail, When, Where and How Accident Occurred, or Nature of Disability and First Symptoms:

Is Your Accident or Illness Related to Your Occupation?: Yes No **If Yes, Explain:**

Have You Filed a Workers' Compensation Claim?: Yes No *(Please Explain Below)* **If No, Do You Intend To?:** Yes No

Are You Receiving Any of the Following *(Check Each Benefit You Are Receiving)*?:

TYPE OF BENEFIT	AMOUNT	BEGIN DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)	TYPE OF BENEFIT	AMOUNT	BEGIN DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)
Workers' Compensation	$			Unemployment	$		
Social Security	$			Other *(Individual or Group)**	$		
State Mandated Disability	$			Auto Insurance Wage Replacement*	$		

***IF YES, GIVE NAME AND ADDRESS OF INSURER BELOW:**

Insurer Name(s) and Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

NOTE: IF THIS FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.

SECTION I | EMPLOYEE STATEMENT (CONTINUED)

When Were You First Treated For Your Illness or Accident *(mm/dd/yyyy)*?:

Name of Healthcare Provider(s) Consulted *(Last, First, MI)*:	**Date Consulted** *(mm/dd/yyyy)*:
	Phone:
Name of Hospital(s):	**Date Admitted** *(mm/dd/yyyy)*:
	Date Discharged *(mm/dd/yyyy)*:

Have You Ever Had Same or Similar Condition In the Past?: Yes No **If Yes, List Name and Address of Hospital/Doctor Below:**

Name of Physician(s) Consulted *(Last, First, MI)*:	**Date Consulted** *(mm/dd/yyyy)*:
	Date Admitted *(mm/dd/yyyy)*:
	Date Discharged *(mm/dd/yyyy)*:
Name of Hospital(s):	**Date Admitted** *(mm/dd/yyyy)*:
	Date Discharged *(mm/dd/yyyy)*:

If benefits are approved and you wish to have optional additional withholding from your check for Federal Income Tax purposes, please submit a completed IRS form W-4S. A link to the form is located on our website at **RenaissanceBenefits.com/claim-forms.**

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

X _____ _____

Signature of Employee *(Your signature is required for benefit consideration)* **Date Signed** *(mm/dd/yyyy)*

NOTE: IF THIS FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.

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—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.