Renaissance®
DENTAL • VISION • LIFE • DISABILITY

CLAIMS SUBMISSION FOR:
LONG TERM DISABILITY ("LTD")

GROUP LONG TERM DISABILITY ("LTD") CLAIM FORM

-Please Print or Type in Dark Ink-

INSTRUCTIONS:

To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays. This claim application 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 SECTIONS TO BE COMPLETED IN THIS FORM:

- **SECTION I:** Employee Statement
  - **SECTION I.A:** Employee Authorization
- **SECTION II:** Employer Statement
- **SECTION III:** Physician Statement

B. SEND COMPLETED FORM TO:

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

FOR QUESTIONS CALL US AT: 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)*:

Social Security Number:	☐ Male ☐ Female	**Date of Birth** *(mm/dd/yyyy)*:		
Street Address *(Include Apt#/Suite)*:		**City:**	**State:**	**ZIP Code:**
Phone Number:		**Height:** _____	**Weight:** _____lbs	

Employer Name:

Occupation:	**List Occupation Duties:**
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 Disability	$			☐ Auto Insurance Wage Replacement*	$		
☐ Canadian Pension Plan	$						

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

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

NOTE: IF CLAIM 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)*:
	Admitted *(mm/dd/yyyy)*:
	Discharged *(mm/dd/yyyy)*:
Name of Hospital(s):	**Date Admitted** *(mm/dd/yyyy)*:
	Date Discharged *(mm/dd/yyyy)*:

If benefits are approved, do you want the minimum $88.00 per month withheld from your check for Federal Income Tax purposes?: ☐ Yes ☐ No **If you want more withheld, please state dollar amount you want withheld $** _____

The Above Statements Are True and Complete to the Best of My Knowledge and Belief.
(Your signature is required for benefit consideration)

X _____ _____

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

SECTION I.A | AUTHORIZATION AND DISCLOSURES:

TO:

- Physicians and Other Health Care Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
- Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors
- Governmental Agencies *(including and not limited to the Social Security Administration, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)*
- Hospitals, Clinics and Health Care Facilities
- Insurers and Pre-Paid Health Plans
- Pharmacies and Pharmacy Benefit Managers
- State Vocational Rehabilitation Agencies and other providers of rehabilitation services
- Medical Information Bureau (MIB) or other companies, which collect health and insurance information
- Attorney Representatives

YOU ARE AUTHORIZED TO PROVIDE INFORMATION RELATED TO MY HEALTH CONDITION AND JOB MODIFICATIONS/ ACCOMMODATIONS WITH MY CURRENT OR FUTURE EMPLOYER TO:

- Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Insurance Company of New York (Renaissance);
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

THIS INCLUDES, BUT IS NOT LIMITED TO, ANY:

- Records, test results, data, and information about health care history, diagnosis, prognosis, treatment, and supplies;
- Employment-related information;
- Income-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; or
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I UNDERSTAND THAT THE INFORMATION BEING DISCLOSED MAY INCLUDE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AND ACCOMPANYING REGULATIONS (HIPAA), INFORMATION REGARDING MENTAL HEALTH CONDITIONS AND THE USE OF DRUGS OR ALCOHOL, AND INFORMATION REGARDING THE HUMAN IMMUNODEFICIENCY VIRUS (HIV).

I UNDERSTAND THAT THE INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING, MANAGING AND/OR ADMINISTERING BENEFITS FOR SHORT TERM DISABILITY, LONG TERM DISABILITY, SALARY CONTINUATION, WORKERS' COMPENSATION OR ANY OTHER BENEFIT PROGRAM OFFERED BY AND THROUGH THE EMPLOYER (HEREINAFTER COLLECTIVELY REFERRED TO AS "BENEFITS PROGRAM"), DEVELOPING A VOCATIONAL REHABILITATION PLAN, AND OTHER PURPOSES IN CONNECTION WITH THE ADMINISTRATION OF THE BENEFITS PROGRAM.

I FURTHER AUTHORIZE RE-DISCLOSURE OF ANY INFORMATION OBTAINED OR DEVELOPED IN THE COURSE OF MANAGING AND/OR ADMINISTERING THE BENEFITS PROGRAM TO THE PLAN ADMINISTRATOR OR CLAIM ADMINISTRATOR OF ANY BENEFITS PROGRAM UNDER WHICH I MAY BE A PARTICIPANT, CLAIMS INVESTIGATORS, ATTORNEYS, PHYSICIAN CONSULTANTS AND OTHER SERVICE PROVIDERS, INCLUDING TREATING PHYSICIAN(S), SOLELY FOR THE PURPOSE OF EVALUATING, ANALYZING, MANAGING AND/OR ADMINISTERING THE BENEFITS PROGRAM. I UNDERSTAND THAT INFORMATION RE-DISCLOSED PURSUANT TO THIS AUTHORIZATION WILL NO LONGER BE PROTECTED UNDER HIPAA. I UNDERSTAND THAT THIS AUTHORIZATION SHALL REMAIN IN FORCE FOR THE DURATION OF MY CLAIM FOR BENEFITS OR SUCH SHORTER PERIOD AS MANDATED BY APPLICABLE LAW. I ALSO UNDERSTAND THAT I HAVE THE RIGHT UPON REQUEST TO RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AND EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME BY MY GIVING WRITTEN NOTICE THAT IS SIGNED BY ME. I UNDERSTAND THAT ANY SUCH REVOCATION SHALL NOT APPLY TO ANY DISCLOSURE OR RE-DISCLOSURE OF INFORMATION MADE IN RELIANCE ON MY INITIAL AUTHORIZATION. I ALSO UNDERSTAND THAT MY FAILURE TO SIGN THIS AUTHORIZATION, OR MY SUBSEQUENT REVOCATION OF THIS AUTHORIZATION, MAY IMPAIR THE ABILITY OF RENAISSANCE TO PROCESS MY CLAIM AND MAY LEAD TO THE DENYING OR TERMINATING OF MY CLAIM FOR BENEFITS.

X _____ _____

Claimant Signature *(Required)* **Date Signed** *(mm/dd/yyyy)*

_____ _____

Claimant Full Printed Name **Date of Birth** *(mm/dd/yyyy)*

*(If the insured is unable to sign, an authorized representative may sign below for the insured)***:**

X _____ _____

Authorized Representative Signature **Date Signed** *(mm/dd/yyyy)*

_____

Description of Representative's Authority to Sign

SECTION II | EMPLOYER STATEMENT

Employer Name:		**Policy Number:**	
Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Phone:	**Fax:**	**Email:**	
Employee Name *(Last, First, MI)*:		**Social Security Number:**	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Regularly Scheduled Hours Per Week:		**Date of Birth:**	
Date of Hire *(mm/dd/yyyy)*:	**Employee STD Effective Date** *(mm/dd/yyyy)*:	**Employee LTD Effective Date** *(mm/dd/yyyy)*:	
Occupation:	**A Job Description is Required if Employee is Out of Work More Than 6 Weeks:**		
Policy Class:			

Employee's Work Schedule: ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal

Check Regular Workdays: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

If Not at Work When Disability Began, Check Status & Provide Date:
☐ Terminated ☐ Leave of Absence ☐ Laid Off ☐ Sick Leave ☐ Vacation
☐ Resigned ☐ Other: _____ **Date** *(mm/dd/yyyy)*: _____

How Was Employee Paid *(Check Frequency and Types)***?:**
Frequency?: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly
Type(s): ☐ Hourly ☐ Salary ☐ Bonus ☐ Commission

Salary Prior to Date Last Worked:
Base Weekly Wages: $ _____
W-2 Earnings: $ _____
Overtime: $ _____
Commissions: $ _____
Bonus: $ _____

Date Last Salary Increase *(mm/dd/yyyy)*:

Employee Work Schedule at Time Last Worked:
Days Per Week: _____ Hours Per Week: _____

Date Last Worked *(mm/dd/yyyy)*: **Hours Worked That Day:**

Has Employee Returned to Work?: ☐ Full Time
☐ Yes ☐ No If yes, Date: _____ ☐ Part Time

EMPLOYEE IS RECEIVING OR ELIGIBLE FOR:	YES /NO	IF YES, WEEKLY / MONTHLY AMOUNT	WK / MO	PROVIDER NAME/NOTES	DATE BENEFITS BEGIN (MM/DD/YYYY)	DATE THROUGH (MM/DD/YYYY)
Salary Continuation	☐ ☐	$	☐ ☐			
PTO	☐ ☐	$	☐ ☐			
Vacation/Sick	☐ ☐	$	☐ ☐			
Disability Pension	☐ ☐	$	☐ ☐			
Retirement Pension	☐ ☐	$	☐ ☐			
State Disability	☐ ☐	$	☐ ☐			
Unemployment	☐ ☐	$	☐ ☐			
Social Security	☐ ☐	$	☐ ☐			
Workers' Compensation	☐ ☐	$	☐ ☐			
Has Workers' Comp. Claim Been Filed?	☐ ☐	IF WORKERS' COMPENSATION HAS BEEN DENIED, SUBMIT COPY OF DENIAL WITH THIS CLAIM.				

Percentage of Premium Paid By Employer _____ %
(If Unanswered, 100% Employer Contribution Will Be Assumed and Applicable Taxes Will Be Withheld)

If the Employee Contributes Toward the Premium, Contributions are Made: ☐ **Pre-Tax** ☐ **Post-Tax**
(If Unanswered, Post-Tax Will Be Assumed)

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SECTION II | EMPLOYER STATEMENT (CONTINUED)

Does Your Company Have a Rehire or Return to Work Policy for Disabled Employees?: ☐ Yes ☐ No

What is the Name of the Person We Should Contact if We Identify a Return to Work Option?:

Name/Address of the Employee's Medical Insurance Carrier or HMO *(provide policy or ID No.)*:

Name of Person Completing this Form:

Phone:	**Fax:**	**Email:**

The Above Statements Are True and Complete to the Best of My Knowledge:

X _____ _____

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

-YOUR MEDICAL PROVIDER IS REQUIRED TO COMPLETE THE NEXT SECTION-

YOUR MEDICAL PROVIDER IS REQUIRED TO COMPLETE THE SECTION BELOW:

SECTION III | PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT

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

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

Patient Is/Was Unable to Work Due To *(Check One)*: ☐ Injury ☐ Illness ☐ Pregnancy

Diagnosis *(Include Complications and ICD 10)*:

FOR NORMAL PREGNANCY, COMPLETE THE FOLLOWING ITEMS, THEN SKIP TO "DATE OF FIRST VISIT":

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

Date You Advised Patient to Stop Working *(mm/dd/yyyy)*:

FOR ALL CONDITIONS EXCEPT NORMAL PREGNANCY, COMPLETE THE FOLLOWING ITEMS

When Did Symptoms First Appear or Accident Happen *(mm/dd/yyyy)***?:**	**Is Condition Due to Injury or Illness Arising Out of Patient's Employment?:** ☐ Yes ☐ No

Has Patient Ever Had Same or Similar Condition?: ☐ Yes ☐ No *(If Yes, State When and Describe)*:

Date of First Visit *(mm/dd/yyyy)* :	**Date Last Visit** *(mm/dd/yyyy)*:	**Frequency of Visits:**

Objective Findings *(X-Rays, EKG's, Lab Data and Clinical Findings)*:	**Subjective Symptoms:**

Nature of Treatment *(Surgery, Medications, Etc.)* **Provide Medication Dosage and Frequency:**

Names and Addresses of Other Physicians:

Has Patient Been Hospitalized?: ☐ Yes ☐ No
If Yes, Give Name and Address:

From *(mm/dd/yyyy)*: _____
To *(mm/dd/yyyy)*: _____

Restrictions *(What the Patient <u>SHOULD NOT</u> Do)*:	**Limitations** *(What the Patient <u>CANNOT</u> Do)*:

Mental Impairment (If Applicable) Provide DSM-5 AXIS Diagnosis:

1. _____
2. _____
3. _____
4. _____
5. _____

SECTION III | PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT (CONTINUED)

If This is a Cardiac Condition, What is the Functional Capacity? *(American Heart Association)*

☐ Class 1–No Limitation ☐ Class 2–Slight Limitation ☐ Class 3–Marked Limitation ☐ Class 4–Complete Limitation

Has Maximum Medical Improvement Been Achieved?: ☐ Yes ☐ No **If No, When Do you Expect a Fundamental Change:**

☐ 1-2 Weeks ☐ 3-4 Weeks ☐ 5-6 Weeks ☐ More than 6 Weeks

If Employer Can Accommodate Patient's Limitations and Restrictions, Is Patient Able to Return to Work?: ☐ Yes ☐ No

If Yes, What Date Could Employment Begin *(mm/dd/yyyy)?*:

Print Name *(Last, First, MI)*:		**License Number:**	
Specialty:	**Phone:**	**Tax ID:**	
Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

X _____ _____

Physician or Health Care Provider Signature *(Required) (No Stamp)* **Date Signed** *(mm/dd/yyyy)*

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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.

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