Renaissance

DENTAL · VISION · LIFE · DISABILITY

GROUP LIFE INSURANCE AND ACCIDENTAL DEATH CLAIM FORM

TO BE USED FOR: CLAIMANT, EMPLOYEE/MEMBER AND DEPENDENTS

—Please Type Or Print Clearly In Dark Ink—

THE CLAIM SHOULD BE SENT TO OUR HOME OFFICE WITHIN 90 DAYS OF THE LOSS, OR AS SOON AS REASONABLY POSSIBLE.

Ⓐ THERE ARE TWO (2) PRIMARY SECTIONS TO BE COMPLETED, SIGNED AND DATED IN THIS FORM:

SECTION 1: Claimant Statement−If multiple beneficiaries were named, each Beneficiary must complete a separate Claimant statement. If the Beneficiary is a minor the appropriate legal representative *(executor, administrator or guardian)* must complete and sign the form with his or her title *(executor, administrator or guardian)*. Please include the following documents:Copy of legal appointment *(if any)*

Certified copy of the death certificate or other lawful evidence providing equivalent information.

Photocopy of the beneficiary's death certificate *(if primary beneficiary has predeceased the insured)*. Policy death proceeds will be paid to the contingent beneficiary, if applicable. If no living beneficiary remains, death proceeds will be paid in accordance with the terms of the policy.

Copy of the itemized bill

For Accidental Death please include the following documents:

Autopsy Report *(if any)*

Police/Accident Reports *(if any)*

Newspaper Article *(if any)*

SECTION 2: Employer or Plan Administrator Statement−Please include the following documents:Copy of all beneficiary changes

The most recent payroll record for one full pay period prior to the employee's last day

Employee's original enrollment form *(if any)*

Original assignment of benefits form, specifying assignment amount, if death proceeds are to be assigned to a funeral home

Ⓑ SEND FULLY COMPLETED FORM TO PLAN ADMINISTRATION AT:

BY MAIL: P.O. Box 413, Somers CT. 06071

OR

BY FAX TO: 860-272-1136

SECTION I | CLAIMANT STATEMENT

Name of Employee *(Last, First, MI)*:

Social Security Number:

Date of Birth *(mm/dd/yyyy)*:

Street Address *(Include Apt#/Suite)*:

City:

State:

ZIP Code:

Date Deceased Last Worked *(mm/dd/yyyy)*:

Occupation:

Date of Death *(mm/dd/yyyy)*:

Place of Death:

Cause of Death: ☐ Natural ☐ Suicide ☐ Homicide ☐ Unknown ☐ Accidental Death ☐ Other _____

If Accidental Death, Date of Accident *(mm/dd/yyyy)*:_____ Time of Accident:_____ ☐ a.m. ☐ p.m.

Detailed Description of Accident *(If Applicable)*:

SECTION I.A | CLAIMANT INFORMATION

Claimant's Relationship to Deceased:

Claimant Name *(Last, First, MI)*:

Social Security Number:

Date of Birth *(mm/dd/yyyy)*:

Claimant Address *(Include Apt#/Suite)*:

City:

State:

ZIP Code:

Phone:

Email:

SECTION I.B | BENEFICIARY INFORMATION

Beneficiary's Relationship to Deceased ☐ Spouse ☐ Ex-Spouse ☐ Child ☐ Parent ☐ Other _____

☐ Male
☐ Female

Beneficiary Name *(Last, First, MI)*:

Date of Birth *(mm/dd/yyyy)*:

Beneficiary Address *(Include Apt#/Suite)*:

City:

State:

ZIP Code:

Phone:

Email:

Benefit Payment Options: If Other Than Lump Sum is Requested, Please Contact **844-368-6485**.

Taxpayer Identification Number and Certification *(For Most Individuals, This is the Beneficiary's SSN)*:

Social Security Number: _____ **Trust Identification Number:** _____

Federal Tax Classification: ☐ Individual/Sole Proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership
☐ Trust/Estate ☐ Limited Liability Company (LLC) ☐ Other _____

Exempt Payee Code *(If Any)*:

Exemption From FATCA Reporting Code *(If Any)*:

SECTION I.C | CLAIMANT CERTIFICATION

UNDER PENALTIES OF PERJURY, I CERTIFY THAT:

(1) THE NUMBER SHOWN IN THIS APPLICATION IS MY CORRECT TAXPAYER IDENTIFICATION NUMBER (OR I AM WAITING FOR A NUMBER TO BE ISSUED TO ME), AND

(2) I AM NOT SUBJECT TO BACKUP WITHHOLDING BECAUSE A. I AM EXEMPT FROM BACKUP WITHHOLDING, OR B. I HAVE NOT BEEN NOTIFIED BY THE INTERNAL REVENUE SERVICE ("IRS") THAT I AM SUBJECT TO BACKUP WITHHOLDING AS A RESULT OF A FAILURE TO REPORT ALL INTEREST AND DIVIDENDS, OR C. THE IRS HAS NOTIFIED ME THAT I AM NO LONGER SUBJECT TO BACKUP WITHHOLDING, AND

(3) I AM A U.S. CITIZEN OR OTHER U.S. PERSON (INCLUDING A U.S. RESIDENT ALIEN) FOR U.S. FEDERAL INCOME TAX PURPOSES, AND

(4) THE FATCA CODE(S) ENTERED ON THIS FORM (IF ANY) INDICATING THAT I AM EXEMPT FROM FATCA REPORTING IS CORRECT.

YOU MUST CROSS OUT ITEM (2) ABOVE IF YOU HAVE BEEN NOTIFIED BY THE IRS THAT YOU ARE CURRENTLY SUBJECT TO BACKUP WITHHOLDING BECAUSE YOU HAVE FAILED TO REPORT ALL INTEREST AND DIVIDENDS ON TAX RETURNS.

THE UNDERSIGNED BENEFICIARY DECLARES THAT THE FOREGOING STATEMENTS ARE TRUE AND COMPLETE AND AGREES TO FURNISH ADDITIONAL INFORMATION AND DOCUMENTATION AS MAY BE REQUIRED. IT IS UNDERSTOOD THAT THE FURNISHING OF FORMS BY RENAISSANCE DOES NOT CONSTITUTE AN ADMISSION THAT THERE IS ANY INSURANCE IN FORCE OR PROCEEDS PAYABLE, NOT DOES IT CONSTITUTE AN ADMISSION OF ANY LIABILITY.

THE IRS DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE ABOVE CERTIFICATIONS TO AVOID BACKUP WITHHOLDING.

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND I HAVE READ THE APPLICABLE STATE FRAUD WARNING NOTICE CONTAINED IN THIS DOCUMENT.

X _____ _____

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

X _____ _____

Signature of Authorized Representative for Named Beneficiary **Printed Name**

_____

Signed At *(City/State)*

_____ _____

Name of Authorized Representative For Named Employer *(Print)* **Title**

X _____ _____

Signature of Authorized Representative For Named Employer *(Required)* **Date Signed** *(mm/dd/yyyy)*

SECTION II | EMPLOYER OR PLAN ADMINISTRATOR STATEMENT

Employer Name *(Last, First, MI)*:		**Policy Number:**	
		Employer Tax ID or EIN:	
Employer's Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Phone:	**Email:**	**Fax Number:**	
Employee Name *(Last, First, MI)*:		**Social Security Number:**	
		Occupation:	
Employee Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

	INSURANCE AMOUNT:	EFFECTIVE DATE (MM/DD/YYYY)
Date of Employment *(mm/dd/yyyy)*:		
Last Day of Active Employment *(mm/dd/yyyy)*:	**Basic Employee Life:** $_____	
Was Employment Terminated Prior to Death? ☐ Yes ☐ No	**Optional Employee Life:** $_____	
If "Yes", Effective Date of Termination *(mm/dd/yyyy)*: _____	**AD&D:** $_____	
Employee Policy Certification:	**Dependent Life:** $_____	

If Employment Terminated Prior to Death, Please Specify: ☐ Dismissed ☐ Leave of Absence ☐ Disability ☐ Resigned ☐ Retired ☐ Layoff ☐ Other: _____

Annual Salary On Date Last Worked: $_____ ☐ Full-Time ☐ Part-Time

Effective Date of Spouse/Dependent Group Life Insurance and AD&D Coverage *(mm/dd/yyyy)*:

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS ACCURATE AND HAS BEEN AN ELIGIBLE, THE ACTIVE EMPLOYEE FOR WHOM PREMIUMS HAVE BEEN, PAID. I HAVE READ THE APPLICABLE STATE FRAUD WARNING NOTICE CONTAINED IN THE THIS DOCUMENT.

X _____ _____

Signature of Authorized Representative for Named Employer: **Date Signed** *(mm/dd/yyyy)*

Title of Authorized Representative:	**Phone:**
	Fax Number:
Email:	

—State Fraud Warnings on Following Pages—

STATE FRAUD WARNING STATEMENTS: THE LAWS OF THE STATES BENEATH REQUIRE THE COMPANY TO PROVIDE THE FOLLOWING STATEMENTS

The laws of the states beneath require the Company to provide the following statements:

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

CT: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

DE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: 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.

ID: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN: A person who knowingly and with intent to defraud a insurer files a statement of claim containing an false, incomplete, or misleading information commits a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in NH R.S.A. REV Stat ANN 638.20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: 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.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

PA: 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 subjects such person to criminal and civil penalties.

PR: Any person who knowingly and with the intention of defrauding presents false information to an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are [sic] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.