Renaissance
DENTAL · VISION · LIFE · DISABILITY
P.O. Box 1596 Indianapolis, IN 46206

NEW YORK
Renaissance Health Insurance
Company of New York

Dental and Vision Eligibility *Enrollment/Change/Waiver*

☐ **Dental** Dental Plan Selection *(if applicable)*: _____ ☐ **Vision**

Type of Update—*please indicate type of update and fill in appropriate information*

☐ Waive Benefits ☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination of Benefits
if you are waiving your benefits please see page two

Effective Date of Change *(if applicable)*: _____ Change is for: ☐ Subscriber ☐ Dependent(s)

Employer Information

Group Name: _____ Subgroup Name *(if applicable)*: _____
Group Number: _____ Subgroup Number *(if applicable)*: _____

Subscriber Information—*please complete for all enrollments/changes* ☐ Check if New Address

Status: ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving

Full Name: _____ Social Security Number: _____
First M.I Last
Street Address: _____ Suite/Apartment: _____
City: _____ State: _____ ZIP Code: _____
E-mail Address: _____ Phone: _____
Company Name: _____ Job Title: _____
Birth Date: ____/____/____ Date of Hire: ____/____/____ Coverage Effective Date: ____/____/____
MM / DD / YYYY MM / DD / YYYY MM / DD / YYYY

Spouse/Dependent Information—*please fill in spouse/dependent information for first-time enrollment or corrections*

Print Full Legal Name *(first, MI, last)*	Relationship	Dental		Vision		Birth date *(mm/dd/yyyy)*	Status *(if applicable)*
		add	drop	add	drop		
	SPOUSE	☐	☐	☐	☐		☐ Surviving
	DEPENDENT ONE	☐	☐	☐	☐		☐ Surviving ☐ Disabled ☐ Legal
	DEPENDENT TWO	☐	☐	☐	☐		☐ Surviving ☐ Disabled ☐ Legal
	DEPENDENT THREE	☐	☐	☐	☐		☐ Surviving ☐ Disabled ☐ Legal
	DEPENDENT FOUR	☐	☐	☐	☐		☐ Surviving ☐ Disabled ☐ Legal

THIS POLICY PROVIDES DENTAL/VISION BENEFITS ONLY. REVIEW YOUR POLICY CAREFULLY.

Printed Subscriber Name: _____

I request coverage under my employer's group insurance plan and authorize my employer to make deductions from my earnings of the required contributions, if any, toward the cost of the coverage. I will be provided a certificate of coverage in either electronic or paper form. By signing below, I consent to electronic delivery of my certificate of coverage and related documents pursuant to the Terms for Paperless Delivery *(attached to this form)*. Such terms provide the manner in which I can request a paper copy at any time.

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.

Subscriber Signature: _____ Date: _____

WAIVE COVERAGE—*if you are waiving coverage, complete this section.* *(waiver may not be allowed for this plan, check with your employer)*

Waive Coverage for *(check all that apply)*: ☐ Myself ☐ Spouse ☐ Child(ren) Only

I hereby certify that I understand that I am eligible for the dental and/or vision coverage offered by Renaissance Health Insurance Company of New York. I hereby decline coverage.

Printed Name: _____ Signature: _____

Name of Employer: _____ Date: _____

IF RENAISSANCE COVERAGE IS WAIVED BECAUSE OF COVERAGE THROUGH ANOTHER SOURCE:

Name of Other Dental/Vision Carrier: _____

Subscriber's Name: _____ Subscriber's SSN: _____

HELPFUL TIPS—*If you have any questions completing this form, your Human Resources or Personnel Department can assist you.*

SUBSCRIBER INFORMATION—*this section should be completed in order to manage your enrollment or update your information. All this information should apply to you, the subscriber. Please write clearly or type.*

Status Definitions—*please select only **one** status:*

- **Active**—*current/active subscriber*
- **Retiree**—*retired and your group is providing benefits*
- **COBRA**—*no longer an active subscriber, but you have self-paid continuous coverage with COBRA. (employers may be required to offer the self-paid extended coverage to certain employees/beneficiaries who qualify and lose their health care benefits coverage. Confirm with your Human Resource/Personnel Department.)*
- **Surviving**—*surviving spouse/child of a deceased subscriber.*

TYPE OF UPDATE—*please select **all** that apply*

- **Waive**—*waiving benefits for yourself or dependents.*
- **New Enrollment**—*first time enrolling yourself or dependents.*
- **Reinstatement**—*reinstate coverage for yourself or dependents.*
- **Change/Correction To Information**—*submitting any change to information/benefits for yourself or dependents.*
- **Termination of Benefits**—*terminate coverage for yourself or dependents.*

SPOUSE/DEPENDENT INFORMATION—*this section should be completed when: registering spouse/dependents or making changes/corrections to information that was previously submitted to Renaissance. Please include full name and the type of coverage for any individual for whom you are enrolling or making a change or amendment.*

Definitions of Dependent Status—*please select **all** that apply*

- **Surviving**—*spouse or child of a deceased subscriber.*
- **Legal**— *an individual over whom the subscriber has legal guardianship or a similar arrangement that confers authority (and the corresponding duty) to care for the person and property of the individual under applicable law.*
- **Disabled**—*a legal dependent who is permanently disabled before the date his/her coverage would otherwise end because of age.*

Renaissance®

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Underwritten by Renaissance Health Insurance Company of New York, NY. The Company can be reached at PO Box 1596, Indianapolis, IN 46206.
In certain states, vision coverage may be underwritten by Vision Service Plan Insurance Company or VSP Vision Care, Inc. Both companies can be reached at 3333 Quality Drive, Rancho Cordova, CA 95670.