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

NEW YORK
Renaissance Health Insurance
Company of New York

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 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 please feel free to contact your Renaissance representative.

(Shaded area is for Renaissance use only)

Group Number: _____ **Group Name:** _____

Sub-Group Names *(if applicable)*: _____

Requested Effective Date: _____ Renewal Date: _____

Amount Paid By Employer For: Employee Coverage: _____ Dependent Coverage: _____

Definition Of Subscriber *(for example: "all full-time employees, all full-time and part-time employees.")*: _____

_____

Can Employees Opt-out-of Dental/Vision Plan?: ☐ Yes ☐ No Is There A Section 125 Plan In Place?: ☐ Yes ☐ No

Is This A Management Carve-Out? ☐ Yes ☐ No Number of Eligible Employees: _____

Estimated Number of Employees Enrolling: _____ Benefit Year: ☐ Calendar Year ☐ Policy Year ☐ Other: _____

New Employee Waiting Period *(check one)*: Waived At Initial Enrollment?: ☐ Yes ☐ No

☐ First of the Month Following: _____ Days ***Or*** ☐ First Day Following _____ Days ***Or*** ☐ Date Of Hire

Tax Identification Number: _____

Group Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Telephone: _____ Fax Number: _____

Billing Contact: _____ Title: _____

E-Mail Address: _____

Billing Address *(if different from above)*: _____

City: _____ State: _____ Zip Code: _____

Group Administrator: _____ Title: _____

E-Mail Address: _____

Previous Carrier: ☐ No ☐ Yes *If Yes, Please Indicate Carrier:* _____

Enrollment By: ☐ Form ☐ Electronic Media *If Electronic Media, Please Specify Type:* _____

Delivery Method For The Group Policy, Individual Subscriber Certificate And Summary: ☐ Electronic ☐ Paper

If Paper Method Is Selected, Send Materials To: _____

_____

By checking the electronic box, you are agreeing to receive such materials electronically pursuant to the terms for paperless delivery attached to this application form. If none selected, all materials will be sent by hard copy.

Enrollee ID Cards Sent To: ☐ Group ☐ Member Home

IMPORTANT NOTE: PROPOSAL MUST BE ATTACHED FOR APPLICATION TO BE COMPLETED.

Benefits Included In Proposal *(check all that apply)*: ☐ Dental ☐ Vision Proposal Attached: ☐ Yes

[Life & Disability Included In A Separate Proposal: ☐ Yes ☐ No
Life & Disability information is used for internal operations purposes only]

ERISA Information Schedule A (Form 5500) Required?: ☐ Yes ☐ No

Reports Required *(additional charges may apply)*: _____

_____

_____

Special Instructions: _____

_____

_____

(Shaded Area for Agents Only) New Agent/Agency?: ☐ Yes ☐ No *(if yes, attach New Agent Documentation)*

Agent Name: _____ Agency Name: _____

Agent License Number: _____ County: _____

Street Address: _____ City: _____

State: _____ ZIP Code: _____ Telephone: _____ Fax number: _____

E-Mail Address: _____

Commission: ☐ Standard ☐ Split *(if split please check one that applies)*: ☐ 50/50 ☐ Other *(please indicate)*_____

2nd Agent Name *(if applicable)*: _____ Agency Name: _____

Agent License Number: _____ County: _____

Street Address: _____ City: _____

State: _____ ZIP Code: _____ Telephone: _____ Fax number: _____

E-Mail Address: _____

New Agent/Agency?: ☐ Yes ☐ No *(if yes, attach New Agent Documentation)*

General Agent *(if applicable)*: _____

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Renaissance in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Renaissance. This requirement is a condition to eligibility for receiving compensation under Renaissance's Agency/Agent compensation program as described in Renaissance's Agency/Agent Agreement. Renaissance will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this Application I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Renaissance related to the client's purchase of a Renaissance benefit plan.

Signature of Agent: _____ **Date:** _____

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 Policy of which this application becomes a part. It is agreed that the employer has 15 days from the date of delivery of the Policy to return the Policy to Renaissance's corporate headquarters for a full refund. If the employer exercises this right, the Policy will terminate on the Effective Date as if no coverage was ever in force, and all money received will be returned.

In addition to the commissions and/or fees identified specifically for your benefit plan, the Agency or Agent may qualify for additional compensation payments from Renaissance related to your purchase of a Renaissance Policy. This additional compensation is not charged to your group.

This application is subject to approval in accordance with Renaissance's guidelines. Misrepresentation of material fact or fraud will cause this application and subsequent Policy to be null and void from the start. **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.**

This type of plan in NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

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

Check # _____ in the amount of $ _____ to be applied as a credit toward the payment of the first month's premium on the proposed Renaissance Policy 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: _____ License # : _____ State: _____

Signature of Renaissance Representative: _____

Renaissance®

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Underwritten by Renaissance Health Insurance Company of New York. The Company may be reached at P.O. 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.