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

WASHINGTON
Renaissance Life & Health
Insurance Company of America

# 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 Life & Health Insurance Company of America *(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. **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 denial of insurance benefit.**

**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: _____

This plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

This plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-888-358-9484 (TTY users call 711).

If you believe that this plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator at PO Box 1596, Indianapolis, IN 46206-1596; by phone at 1-888-358-9484 (TTY users call 711) or fax to 1-888-984-7156. You can file a grievance by mail, fax or phone. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل على الهاتف رقم 1-888-358-9484 (رقم الطابعة الهاتفية: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
1-888-358-9484 (TTY：711)。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-358-9484 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-358-9484 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। कॉल करें
1-888-358-9484 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-358-9484 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-358-9484 (TTY：711) まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-358-9484 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-888-358-9484 (телетайп: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-358-9484 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-358-9484 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-358-9484 (TTY: 711).

ધ્યાન આપો: જો તમે [ગુજરાતી] બોલતાં હો તો વિના મૂલ્ય ભાષાકીય સહાયતા સેવાઓ તમારે માટે ઉપલબ્ધ છે. કૉલ કરો 1-888-358-9484 (TTY: 711).

**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-358-9484 (TTY: 711) تماس بگیرید.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-358-9484 (TTY: 711).

Renaissance®

DENTAL · VISION · LIFE · DISABILITY

Underwritten by Renaissance Life & Health Insurance Company of America, 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.

# NOTICE OF PRIVACY PRACTICES

**Date of This Notice: September 9, 2015**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice describes the privacy practices of Delta Dental Plan of Michigan, Inc., Delta Dental Plan of Ohio, Inc., Delta Dental Plan of Indiana, Inc., Delta Dental Plan of Arkansas, Inc., Delta Dental of Kentucky, Inc., Delta Dental Plan of New Mexico, Inc., Delta Dental of North Carolina, Delta Dental of Tennessee, Renaissance Life & Health Insurance Company of America, Renaissance Health Insurance Company of New York, and Renaissance Systems & Services, LLC (collectively, "we" or "us" or the "Plan"). These entities have designated themselves as a single affiliated covered entity for purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and each has agreed to abide by the terms of this Notice and may share protected health information with each other as necessary for treatment, payment or to carry out health care operations, or as otherwise permitted by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information.

We comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. We maintain a breach reporting policy and have in place appropriate safeguards to track required disclosures and meet appropriate reporting obligations. We will notify you promptly in the event a breach occurs that may have compromised the security or privacy of your PHI. In addition, we comply with the "Minimum Necessary" requirements of HIPAA and the HITECH amendments.

For more information concerning this Notice please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose your PHI.

**For Treatment** We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose PHI about you to providers, including dentists, doctors, nurses, or technicians, who are involved in taking care of you. For example, we might disclose information about your prior dental X-ray to a dentist to determine if the prior X-ray affects your current treatment.

**For Payment** We may use or disclose PHI about you to obtain payment for your treatment and to conduct other payment related activities, such as determining eligibility for Plan benefits, obtaining customer payment for benefits, processing your claims, making coverage decisions, administering Plan benefits, and coordinating benefits.

**For Health Care Operations** We may use and disclose PHI about you for other Plan operations, including setting rates, conducting quality assessment and improvement activities, reviewing your treatment, obtaining legal and audit services, detecting fraud and abuse, business planning and other general administration activities. In accordance with the Genetic Information and Nondiscrimination Act of 2008, we are prohibited from using your genetic information for underwriting purposes.

**To Business Associates** We may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization management, quality assessment, billing and collection or audit services, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

**Health-Related Benefits and Services** We may use or disclose health information about you to communicate to you about health-related benefits and services. For example, we may communicate to you about health-related benefits and services that add value to, but are not part of, your health plan.

**To Avert a Serious Threat to Health or Safety** We may use and disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

**Military and Veterans** If you are a member of the armed forces, we may release PHI about you if required by military command authorities.

**Worker's Compensation** We may release PHI about you as necessary to comply with worker's compensation or similar programs.

**Public Health Risks** We may release PHI about you for public health activities, such as to prevent or control disease, injury or disability, or to report child abuse, domestic violence, or disease or infection exposure.

**Health Oversight Activities** We may release PHI to help health agencies during audits, investigations or inspections.

**Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement** We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**National Security and Intelligence Activities** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**To Plan Sponsor** We may disclose your PHI to certain employees of the Plan Sponsor (i.e., the Company) for the purpose of administering the Plan. These employees will only use or disclose your PHI as necessary to perform Plan administrative functions or as otherwise required by HIPAA.

**Disclosure to Others** We may use or disclose your PHI to your family members and friends who are involved in your care or the payment for your care. We may also disclose PHI to an individual who has legal authority to make health care decisions on your behalf.

## REQUIRED DISCLOSURES

The following is a description of disclosures of your PHI the Plan is required to make:

**As Required By Law** We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

**Government Audits** The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

**Disclosures to You** Upon your request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

## WRITTEN AUTHORIZATION

We will use or disclose your PHI only as described in this Notice**. It is not necessary for you to do anything to allow us to disclose your PHI as described here.** If you want us to use or disclose your PHI for another purpose, you must authorize us in writing to do so. For example, we may use your PHI for research purposes if you provide us with written authorization to do so. You may revoke your authorization in writing at any time. When we receive your revocation, it will be effective only for future uses and disclosures. It will not be effective for any PHI that we may have used or disclosed in reliance upon your written authorization. We will never sell your PHI or use it for marketing purposes without your express written authorization. We cannot condition treatment, payment, enrollment in a Health Plan, or eligibility for benefits on your agreement to sign an authorization.

## ADDITIONAL INFORMATION REGARDING USES OR DISCLOSURES OF YOUR PHI

For additional information regarding the ways in which we are allowed or required to use of disclosure your PHI, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

## YOUR RIGHTS REGARDING PHI THAT WE MAINTAIN

You have the following rights regarding PHI we maintain about you:

**Your Right to Inspect and Copy Your PHI** You have the right to inspect and copy your PHI. You must submit your request in writing and if you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. A copy will be provided within 30 days of your request.

The Plan may deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Contact Person listed below.

**Your Right to Amend Incorrect or Incomplete Information** If you believe that the PHI the Plan has about you is incorrect or incomplete, you may request that we change your PHI by submitting a written request. You also must provide a reason for your request. We are not required to amend your PHI but if we deny your request, we will provide you with information about our denial and how you can disagree with the denial within 60 days of your request.

**Your Right to Request Restrictions on Disclosures to Health Plans.** Where applicable, you may request that restrictions be placed on disclosures of your PHI.

**Your Right to an Accounting of Disclosures We Have Made** You may request an accounting of disclosures of your PHI that we have made, except for disclosures we made to you or pursuant to your written authorization, or that were made for treatment, payment or health care operations. You must submit your request in writing. Your request may specify a time period of up to six years prior to the date of your request. We will provide one list of disclosures to you per 12-month period free of charge; we may charge you for additional lists.

**Your Right to Request Restrictions on Uses and Disclosures** You have the right to request restrictions or limitations on the way that we use or disclose PHI. You must submit a request for such restrictions in writing, including the information you wish to limit, the scope of the limitation and the persons to whom the limits apply. We may deny your request.

**Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location** You may request that we direct confidential communications to you in an alternative manner (i.e., by facsimile or e-mail). You must submit your request in writing. We are not required to agree to your request, however we will accommodate your request if doing otherwise would place you in any danger.

**Your Right to a Paper Copy of This Notice**

To obtain a paper copy of this Notice or a more detailed explanation of these rights, send us a written request at the address listed below. You may also obtain a copy of this Notice at one of our websites:

www.deltadentalmi.com,
www.deltadentaloh.com,
www.deltadentalin.com,
www.deltadentalar.com
www.deltadentalky.com,
www.deltadentalnc.com,
www.deltadentalnm.com,
www.deltadentaltn.com,
www.renaissancedental.com, or
www.rss-llc.com.

**Your Right to Appoint a Personal Representative**

Upon receipt of appropriate documentation appointing an individual as your personal representative, medical power of attorney or legal guardian, that individual will be permitted to act on your behalf and make decisions regarding your healthcare.

## CHANGES TO THIS NOTICE

We may amend this Notice of Privacy Practices at any time in the future and make the new Notice provisions effective for all PHI that we maintain. We will advise you of any significant changes to the Notice. We are required by law to comply with the current version of this Notice.

## COMPLAINTS

If you believe your privacy rights or rights to notification in the event of a breach of your PHI have been violated, you may file a complaint with us or with the Office of Civil Rights. Complaints about this Notice or about how we handle your PHI should be submitted in writing to the Contact Person listed below.

A complaint to the Office of Civil Rights should be sent to Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775. You also may visit OCR's website at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html for more information.

You will not be penalized, or in any other way retaliated against for filing a complaint with us or the Office of Civil Rights.

**SEND ALL WRITTEN REQUESTS REGARDING THIS PRIVACY NOTICE TO:**

**Jonathan S. Groat**
**Chief Privacy Officer**
**P.O. Box 30416**
**Lansing, MI 48909-7916**
**517-347-5451 (TTY users call 711)**

Para asistencia en español, llame al número de servicio al cliente (customerservice) que se incluye o en el reverso de su tarjeta de identificación.

This document is also available in alternative formats upon request and at no cost to persons with disabilities.

Rev. 8/2015

# FACTS

## WHAT DOES RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA DO WITH YOUR PERSONAL INFORMATION?

**Why?**

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

**What?**

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and Insurance claim information
- Transaction history and Medical information
- Credit card payments and Employment information

When you are *no longer* our customer, we continue to share your information as described in this notice.

**Why?**

All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information; the reasons Renaissance Life & Health Insurance Company of America chooses to share; and whether you can limit this sharing.

| Reasons we can share your personal information | Does Renaissance Life & Health Insurance Company of America share? | Can you limit this sharing? |
|---|---|---|
| **For our everyday business purposes –** such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus | **Yes** | **No** |
| **For our marketing purposes –** to offer our products and services to you | **Yes** | **No** |
| **For joint marketing with other financial companies** | **No** | **We do not share** |
| **For our affiliates' everyday business purposes –** information about your transactions and experiences | **Yes** | **No** |
| **For our affiliates' everyday business purposes –** information about your creditworthiness | **No** | **We do not share** |
| **For nonaffiliates to market to you** | **No** | **We do not share** |

**Questions?** Call 517-347-5451 or go to www.renaissancedental.com (TTY users call 711)

Para asistencia en español, llame al número de servicio al cliente (customerservice) que se incluye o en el reverso de su tarjeta de identificación.

This notice is also available in alternative formats upon request and at no cost to persons with disabilities.

| What we do | |
|---|---|
| **How does Renaissance Life & Health Insurance Company of America protect my personal information?** | To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. |
| **How does Renaissance Life & Health Insurance Company of America collect my personal information?** | We collect your personal information, for example, when you<br>■ Apply for insurance or Pay insurance claims<br>■ File an insurance claim or Use your credit or debit card<br>■ Give us your contact information |
| **Why can't I limit all sharing?** | Federal law gives you the right to limit only<br>■ sharing for affiliates' everyday business purposes–information about your creditworthiness<br>■ affiliates from using your information to market to you<br>■ sharing for nonaffiliates to market to you<br><br>State laws and individual companies may give you additional rights to limit sharing. |

| Definitions | |
|---|---|
| **Affiliates** | Companies related by common ownership or control. They can be financial and nonfinancial companies.<br>■ *Our affiliates include companies with the Delta Dental name in Michigan, Ohio, Indiana, Kentucky, Tennessee, New Mexico, Arkansas and North Carolina; insurance companies such as Renaissance Life & Health Insurance Company of America and Renaissance Health Insurance Company of New York; and others such as Renaissance Systems & Services, LLC.* |
| **Nonaffiliates** | Companies not related by common ownership or control. They can be financial and nonfinancial companies.<br>■ *Renaissance Life & Health Insurance Company of America does not share your personal information with non-affiliates so they can market to you.* |
| **Joint marketing** | A formal agreement between nonaffiliated financial companies that together market financial products or services to you.<br>■ *Renaissance Life & Health Insurance Company of America does not jointly market with non-affiliated financial companies.* |

| Other important information |
|---|
| **For customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA:** To review your personal information, write to Privacy Officer/Legal Department, 4100 Okemos Road, Okemos, MI 48864. You must state your full name, address, policy number (if applicable) and the information you would like to see. We will tell you what information we have, and you may review and copy it at our office or ask that we mail a copy to you for a fee. If you think that personal information that we have about you is wrong, you may write to us. We will tell you what actions we take because of your letter. If you do not agree with our actions, you may send us a statement. |