



Renaissance[®]

Life & Health Insurance Company of America

STANDARD MEDICARE SUPPLEMENT INSURANCE PLAN

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA
HEALTH ADMINISTRATIVE OFFICE
PO BOX 27248 SALT LAKE CITY, UTAH 84127-0248
STATE OF DOMICILE: INDIANA

Agent Checklist for Completing the Standard Medicare Supplement Application

This packet contains the following forms needed to complete a Standard Medicare Supplement application. Please tear out the **application** and all pages marked **"RETURN TO COMPANY"** and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

Application for Standard Medicare Supplement (Form RENMEDCOMBO-FL 030916)

- If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 7 is not required to be completed.
- Section 5 should be completed if the applicant(s) would like his/her payments to be deducted automatically from his/her checking/savings account. This option only applies if premiums are paid monthly.

Authorization to Release Confidential Medical Information (Form RENHIPAA3-FL 6/1/2017) - Must be completed **only** if applying outside Open Enrollment or a Guaranteed Issue period for Medicare Supplement. If a husband and wife are both applying for coverage on the same application then both must sign the form.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

(Form RENMED-REP-OT 102015) - This form must be completed if any replacement of an existing Medicare Supplement policy is involved. One signed copy must be returned to the Health Administrative Office and the other signed copy must be left with the applicant(s).

Agent Certification (Form RENMED-CERT-FL 6/1/2017) - This form must be signed by the agent and by the applicant(s).

Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you would like to fax the underwriting documents instead of mailing them.

Please note, you are also required to provide the applicant(s) with the following items:

Guide to Health Insurance for People with Medicare

Outline of Coverage

Dental and Vision Outline of Coverage (only required in Maine, Nevada, South Carolina and Texas)

Premiums and Enrollment Fee

Utilize the Outline of Coverage to determine Medicare Supplement premiums:

- Determine ZIP code where the applicant resides and find the correct rate page for that Zip Code.
- Determine Plan.
- Determine if non-tobacco or tobacco.
- Find Age/Gender - Verify that the age and date of birth are the exact age as of the application date, this will be the applicant's base monthly premium.
- Use the Calculate Your Premium form to adjust the monthly premium for different modes and to add the enrollment fee.

There will be a one-time Medicare Supplement enrollment fee of \$25.00 that must be collected with each applicant's initial payment. For a husband and wife written on the same application, \$50.00 in fees must be collected. This will not affect the renewal premiums.

Mailing Address

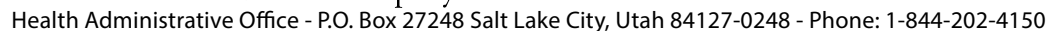
Renaissance Life & Health Insurance Company of America
Health Administrative Office
PO Box 27248
Salt Lake City, UT 84127-0248

Federal Express/UPS

Renaissance Life & Health Insurance Company of America
Health Administrative Office
1405 West 2200 South
Salt Lake City, UT 84119

Fax/Email

Attn: New Business - **ACH Applications 888-433-4795**
ren.newbusiness@insadminservices.com



SECTION 3: PLEASE ANSWER ALL QUESTIONS COMPLETELY

Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage?**

To the Best of Your Knowledge:

1. Are you covered under Medicare Part A?

If "YES," what is your Part A effective date? _____ / _____
Applicant Applicant B

If "NO," what is your eligibility date? _____ / _____
Applicant Applicant B

2. Did you enroll in Medicare Part B in the last six months?

If "YES," what is your Part B effective date? _____ / _____
Applicant Applicant B

If "NO," indicate date you plan to enroll. _____ / _____
Applicant Applicant B

3. Did you turn 65 in the last six months?

Applicant

Yes No

Yes No

Applicant B

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

SECTION 4: FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have. PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge:

1. Are you applying during a Guaranteed Issue period?

(NOTE: If the answer above is "YES," please attach proof of eligibility.)

2. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force?

(a) If "YES," with what company and what plan do you have?

Applicant

Yes No

Yes No

Applicant B

Yes No

Yes No

APPLICANT

APPLICANT B

Name of Company

Name of Company

Policy/Certificate Number

Policy/Certificate Number

Plan

Plan

Issue Date

Issue Date

(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?

(c) If "YES," indicate termination date: _____ / _____
Applicant Applicant B

(d) If "YES," have you received a copy of the replacement notice?

Applicant

Yes No

Yes No

Applicant B

Yes No

Yes No

If you have had any other Medicare plan coverage as referenced below, not to include Medicare Supplement, please complete questions (a-e) below. If not, skip to question #4.

3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START _____ END _____ START _____ END _____
Applicant Applicant B

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

(b) If "YES," have you received a copy of the replacement notice?

(c) Was this your first time in this type of Medicare plan?

(d) Did you drop a Medicare Supplement or Medicare Select policy/certificate to enroll in this Medicare plan?

(e) Is your former Medicare Supplement or Medicare Select policy/certificate still available?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

SECTION 4: CONTINUED

4. Have you had coverage under any health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare Supplement plan.) (a) If "YES," with what company and what kind of policy/certificate? (List below.)	Yes	No	Yes	No
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APPLICANT		APPLICANT B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.

START _____ END _____ START _____ END _____
Applicant Applicant B

5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program," and have not met your "Share of Cost," please answer "NO" to this question.) If "YES,"	Yes	No	Yes	No
(a) Will Medicaid pay your premiums for this Medicare Supplement policy?	Yes	No	Yes	No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes	No	Yes	No

SECTION 5: BILLING INFORMATION

APPLICANT	APPLICANT B
Initial Premium (including enrollment fee)	Initial Premium (including enrollment fee)
$ \begin{array}{ccccccc} \$ & \frac{\quad}{\text{Med Supp}} & + \$ & \frac{\quad}{\text{Enrollment}} & + \$ & \frac{\quad}{\text{Dental}} & + \$ & \frac{\quad}{\text{Vision}} & = \$ & \frac{\quad}{\text{Total}} \\ \text{Premium} & & & \text{Fee} & & \text{Premium} & & \text{Premium} & & \end{array} $	$ \begin{array}{ccccccc} \$ & \frac{\quad}{\text{Med Supp}} & + \$ & \frac{\quad}{\text{Enrollment}} & + \$ & \frac{\quad}{\text{Dental}} & + \$ & \frac{\quad}{\text{Vision}} & = \$ & \frac{\quad}{\text{Total}} \\ \text{Premium} & & & \text{Fee} & & \text{Premium} & & \text{Premium} & & \end{array} $
Amount Collected: _____	Amount Collected: _____
Renewal Premium \$ _____	Renewal Premium \$ _____
Select Premium Payment Option: Annual Semi-annual Quarterly ACH Monthly (direct monthly not available)	Select Premium Payment Option: Annual Semi-annual Quarterly ACH Monthly (direct monthly not available)

I would like my monthly premium payment to come from my (check one) on the _____ day of the month:

Checking (Please attach a voided check)	Savings
---	---------

Please ask your financial institution to verify that this EFT will be accepted, and that the information below is correct.

Financial Institution Name:	Phone #:
-----------------------------	----------

Financial Institution Address:

Transit Routing # (9 digits):	Account #:
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I hereby request and authorize Renaissance Life & Health Insurance Company of America to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Renaissance Life & Health Insurance Company of America or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Renaissance Life & Health Insurance Company of America's rights in respect to each charge shall be the same as if it were a check made payable to Renaissance Life & Health Insurance Company of America and personally signed by me. If any charge is dishonored for any reason, Renaissance Life & Health Insurance Company of America shall not be under any liability even though such dishonor results in the forfeiture of insurance. After the first premium has been paid any termination of coverage will be subject to the Termination provision of the policy.

Signature as it appears on financial institution records	Print name of account owner (if other than proposed insured)	Date
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SECTION 6:

• **During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 6 and GO TO SECTION 7.**

• **NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.**

If either you or Applicant B answer "YES" to any of the following questions, 1-14 or 15A-E, that person is not eligible for Medicare Supplement coverage.

Applicant Height / Weight: Ft. _____ In. _____ Lbs. _____	Applicant B Height / Weight: Ft. _____ In. _____ Lbs. _____
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	Applicant	Applicant B
1. Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home healthcare; or, are you bedridden, wheelchair bound, using oxygen or require the use of a motorized device?	Yes No	Yes No
2. Have you been diagnosed by a licensed physician with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorder?	Yes No	Yes No
3. Have you been diagnosed by a licensed physician with Parkinson's Disease, systemic lupus, scleroderma, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with related fractures, cirrhosis or chronic hepatitis?	Yes No	Yes No
4. Have you been diagnosed by a licensed physician with or taken medication for Alzheimer's Disease, dementia or any other cognitive disorder?	Yes No	Yes No
5. Have you tested positive for exposure to the HIV infection or been diagnosed by a licensed physician as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	Yes No	Yes No
6. Within the past 24 months have you been treated for or been advised by a licensed physician to have treatment for internal cancer, alcohol or drug use, mental or nervous disorder requiring psychiatric care or have you had an amputation caused by disease?	Yes No	Yes No
7. Within the past 24 months have you been treated for or been advised by a licensed physician to have treatment for heart attack, heart, Coronary or Carotid Artery Disease (not including high blood pressure), Peripheral Artery, Vascular or Venous Thrombotic Disease, congestive heart failure or cardiomyopathy, stroke, Transient Ischemic Attack (TIA) or heart rhythm disorder?	Yes No	Yes No
8. Within the past 24 months have you been treated by a licensed physician for degenerative bone disease, crippling/disabling, Rheumatoid Arthritis, Spinal Stenosis or have you been advised to have a joint replacement?	Yes No	Yes No
9. Has a licensed physician advised you to have cataract surgery in the next 12 months?	Yes No	Yes No
10. Has a licensed physician advised you to have surgery, medical tests, treatment or therapy that has not been performed?	Yes No	Yes No
11. Have you been hospital confined three or more times in the last 24 months?	Yes No	Yes No
12. Have you had an organ transplant or been advised by a licensed physician to have an organ transplant?	Yes No	Yes No
13. At any time, have you been medically diagnosed by a licensed physician with, treated for, or had surgery for Chronic Kidney Disease, kidney failure, or had Kidney Disease requiring dialysis?	Yes No	Yes No
14. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes No	Yes No
15. Do you have diabetes that is treated by medication or diet? If "YES", answer 15A-15E	Yes No	Yes No
A. Neuropathy or numbness in your hands, feet or legs?	Yes No	Yes No
B. Retinopathy or eye disorder (other than cataracts)?	Yes No	Yes No
C. Kidney Disease?	Yes No	Yes No
D. Skin ulcers or had an amputation?	Yes No	Yes No
E. Heart disorder (including high blood pressure), poor circulation or Peripheral Artery, Vascular or Venous Thrombotic Disease, history of stroke or TIA?	Yes No	Yes No
16. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If "YES," please list the drug and the condition in the following table.	Yes No	Yes No

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

ADDITIONAL INFORMATION: PART 6- CONTINUED HEALTH/MEDICAL QUESTIONS

	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

IF ADDITIONAL SPACE IS REQUIRED ATTACH SEPARATE SHEET

SECTION 7: RENAISSANCE DENTAL/VISION

Dental and Vision Plan Options Vision is an add-on to the Dental Product. Vision is not available if Dental is not selected. (The amount payable for coverage varies based on the coverage option selected, the number of people enrolled and the payment frequency. You may choose only one option, regardless of the number of people enrolling):

Dental Plan Options: Single Two Person Family Rate

Vision Plan Options: Single Two Person Family Rate

Will this policy replace or change any existing insurance policy? Yes No
If yes, please describe: _____
Company Name: _____ Policy Number: _____

NOTE: This section of this application must be completed in order for us to process your application for Dental and Vision coverage. Please print clearly or type. ONLY complete the Legal Spouse and Dependent information if applicable.

APPLICANT	LEGAL SPOUSE
Dental/Vision Plan	Dental/Vision Plan
Coverage Effective Date: (Date coverage takes effect for you and/or your legal spouse) (Access Code: Internal Use Only)	(Access Code: Internal Use Only)
DEPENDENT CHILD #1	DEPENDENT CHILD #2
Name (First/Middle/Last)	Name (First/Middle/Last)
Date of Birth:	Date of Birth:
Male Female Social Security No. _____	Male Female Social Security No. _____

NOTE: If any additional dependents please include on a separate page.

VALIDATION QUESTION (Choose ONE and answer below)

Mother's maiden name (last name only)	Name of first pet
City in which you were born	Answer: _____

This application is subject to approval, refusal or modification in accordance with Renaissance guidelines. Misrepresentation or fraud will cause this application and subsequent coverage to be null and void from the start. 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.

Applicant Signature Date

SECTION 8: PLEASE READ AND SIGN BELOW**IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I understand a telephone interview may be necessary to verify or supplement information given to Renaissance Life & Health Insurance Company of America on this application. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed.

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.

I wish to apply for a Medicare Supplement insurance policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that the policy applied for will not take effect until it is issued by Renaissance Life & Health Insurance Company of America and all of the following requirements are met: (a) the policy is delivered and accepted, each applicant will receive a separate policy; (b) my policy benefits start no earlier than my Medicare effective date; (c) the first full premium has been paid according to the mode of payment specified in the application, and (d) my application has been approved by Renaissance Life & Health Insurance Company of America.

Dated at _____, on _____, _____
City, State Month Day Year

Applicant's Signature

Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/We have truly and accurately recorded in the application the information supplied by the applicant.

(Signature of Florida Licensed Agent)

(Signature of Florida Licensed Agent)

Florida Agent License Number

Florida Agent License Number

FLORIDA AGENT NUMBER/(STAMP)

FLORIDA AGENT NUMBER/(STAMP)

SECTION 9: AGENT SUPPLEMENT

List any other health insurance policies/certificates you have sold to the applicant.

(a) List policies/certificates sold which are still inforce.

APPLICANT		APPLICANT B	
Name of Company		Name of Company	
Policy/Certificate Number	Form Number	Policy/Certificate Number	Form Number
Description of Benefits		Description of Benefits	
Effective Date of Coverage		Effective Date of Coverage	

(b) List policies/certificates sold in the past five (5) years, which are no longer inforce.

APPLICANT		APPLICANT B	
Name of Company		Name of Company	
Policy/Certificate Number	Form Number	Policy/Certificate Number	Form Number
Description of Benefits		Description of Benefits	
Effective Date of Coverage		Effective Date of Coverage	

SECTION FOR ADDITIONAL COMMENTS

APPLICANT (please attach a separate sheet if needed)	APPLICANT B (please attach a separate sheet if needed)

MEDICARE SUPPLEMENT/DENTAL/VISION INITIAL PREMIUM RECEIPT**MAKE CHECK PAYABLE TO: Renaissance Life & Health Insurance Company of America**

Received from _____ (Proposed Insured) for a policy with Renaissance Life & Health Insurance Company of America (the Company), and \$ _____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company and a policy is issued.

Agent's Name (please print) _____

Agent's Signature _____

Date _____

Florida Agent License Number _____

LEAVE WITH APPLICANT



Renaissance.

Life & Health Insurance Company of America

Health Administrative Office - P.O. Box 27248 Salt Lake City, Utah 84127-0248 - Phone: 1-844-202-4150

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Renaissance Life & Health Insurance Company of America for the purpose of 1) evaluating my application for insurance; 2) obtaining reinsurance; 3) determining or fulfilling responsibility for coverage and provision of benefits; 4) and administering coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians or MIB, Inc., to release any and all records and information to be exchanged between Renaissance Life & Health Insurance Company of America and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

I authorize Renaissance Life & Health Insurance Company of America, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Renaissance Life & Health Insurance Company of America at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Renaissance Life & Health Insurance Company of America may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)

Name of Proposed Insured B (please print)

Signature of Proposed Insured

Signature of Proposed Insured B

Date

Date

RETURN TO COMPANY



Renaissance®

Life & Health Insurance Company of America

Health Administrative Office

P.O. Box 27248 Salt Lake City, Utah 84127-0248

Phone: 1-844-202-4150

MEDICARE SUPPLEMENT REPLACEMENT

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Renaissance Life & Health Insurance Company of America. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT

I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH INSURANCE COVERAGE.

To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

Additional benefits.

No change in benefits, but lower premiums.

Fewer benefits and lower premiums.

My plan has outpatient prescription drug coverage and I am enrolling in Part D.

Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other, (please specify _____)

1. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

2. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent / Broker / Other Representative

Print Name and Address of Issuer / Agent / Broker

Signature of Applicant

Signature of Applicant B, if applying

Date

RETURN TO COMPANY



Renaissance

Life & Health Insurance Company of America
Health Administrative Office
P.O. Box 27248 Salt Lake City, Utah 84127-0248
Phone: 1-844-202-4150

MEDICARE SUPPLEMENT REPLACEMENT

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Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other, (please specify _____)

1. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

2. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent / Broker / Other Representative

Print Name and Address of Issuer / Agent / Broker

Signature of Applicant

Signature of Applicant B, if applying

Date

LEAVE WITH APPLICANT

I the undersigned insurance agent certify; **THAT**, I have taken an application for:

Applicant:

Medicare Supplement

Plan A - RENA10ST-FL
Plan F - RENF10ST-FL
Plan G - RENG10ST-FL
Plan N - RENN10ST-FL

Applicant B:

Medicare Supplement

Plan A - RENA10ST-FL
Plan F - RENF10ST-FL
Plan G - RENG10ST-FL
Plan N - RENN10ST-FL

Offered by **Renaissance Life & Health Insurance Company of America**

to _____
(Applicant(s))

THAT, I have explained the provisions of the policy being applied for, including specifically all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

\$ _____ which has been paid to me by: Check ACH (Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

Date

Signature of Agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

Name of Agency

Signature of Applicant

Address of Agent / Agency

Signature of Applicant, if applying

Phone Number

RETURN TO COMPANY

Renaissance Life & Health Insurance Company of America

Health Administrative Office • PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 1-844-202-4150 • Fax 888-433-4795

Calculate Your Premium

MEDICARE SUPPLEMENT & DENTAL/VISION

Medicare Supplement Plan

Before you begin: If you are not in your Open Enrollment or Guarantee Issue period, please go to page 2 to determine your eligibility for coverage.

Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
Premium Write in your Medicare Supplement plan's monthly premium from the Outline of Coverage table.	\$128.52		
Write in your Dental/Vision plan's monthly premium from the Rate Sheet.	\$59.32		
Add the Medicare Supplement monthly payment and the Dental/Vision payment to determine total premium.	$\$128.52 + \$59.32 = \$187.84$		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	<p>\$187.84 Monthly Payment</p> <p>\$563.52 Quarterly Payment</p> <p>\$1,127.04 Semi-Annual Payment</p> <p>\$2,254.08 Annual Payment</p>		
Enrollment/Policy Fee There is a one-time application fee of \$25.* This will be collected with your initial payment and will NOT affect your renewal premium.	<p>$\\$187.84 + \\$25.00 = \\$212.84$</p> <p>Example shows initial payment (monthly schedule).</p>		

If applying for Dental or Dental/Vision, write in the monthly premium based on the Applicant's state of residence. The monthly premium can be found on the Dental/Vision rate sheet.

If more than one person is applying for Dental/Vision, multiply the monthly premium x the number of people applying. If the Applicant has more than 3 family members applying, the maximum premium amount is the monthly premium X 3.

*If applying for dental only or dental/vision only, do NOT include the \$25.00 application fee in the initial premium payment.

COMPLETE AND RETURN WITH APPLICATION

Renaissance Life & Health Insurance Company of America

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HEIGHT AND WEIGHT CHARTS

To determine whether you may purchase coverage, locate your height, then weight in the charts below. If your weight is not in the Standard column, we are sorry, you are not eligible for coverage at this time. If your weight is located in the Standard column, you may proceed in completing the application.

MEDICARE SUPPLEMENT

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

Initial Premiums Paid through ACH (Automated Clearing House) Medicare Supplement applications may have their initial premium automatically deducted from their checking or savings account through the specific Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Medicare Supplement applications using ACH for the initial premium:

STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.

Applicants wishing to pay electronically complete the appropriate Medicare Supplement Authorization for Electronic Funds Transfer section on the application.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT (888) 433-4795

1) ACH fax transmittal cover sheet on the back of this form

2) Medicare Supplement Application and other required forms including authorization for EFT

If you fax the application, do not mail it as processing errors occur and additional charges could result in the duplication.

For producer use only. Not for use with the general public.

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-888-433-4795

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Producer Name _____

Producer Number _____

Producer Phone Number / Producer Fax Number _____

Comments _____

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NOTES



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Life & Health Insurance Company of America

Renaissance Life & Health Insurance Company of America is part of the Renaissance Family of Companies.

At Renaissance, it is our goal to bring quality to all we do by providing flexible, innovative plans and exceptional customer service. We are proud of our A rating from A.M. Best Company and lead the industry with online tools that make it easy to access and manage information. We provide flexible plan solutions that include, dental, vision and hearing. All of which pair perfectly with our Medicare Supplement plans nationwide.

Our more than 55 years of experience in dental claims processing within the Renaissance Family of Companies has taught us how to innovate, improve operating efficiency and manage costs. We pass the benefits of our experience along to our clients in the form of savings. Collectively our family of companies provides dental coverage for more than 13.1 million people paying out nearly \$3 billion for dental care annually.*

* Renaissance internal data, 2015.

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Health Administrative Office

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