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-PA 8/1/2017)*
- If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 6 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-OT 011316)* - 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-PA 041216)* - 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-OT 102015)* - 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

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

Application For:
- ☐ **Medicare Supplement Coverage**
- ☐ **Medicare Supplement Conversion; Policy Number** _____
- ☐ **Dental/Vision**

Agent Name(s) / Agent Number (s):

SECTION 1: PLAN (to be completed by Agent)

NOTE: For ALL sections, ONLY complete the Applicant B information if second applicant also applying

APPLICANT	APPLICANT B
Medicare Supplement Plan	**Medicare Supplement Plan**
☐A ☐B ☐C ☐D ☐F ☐G ☐N	☐A ☐B ☐C ☐D ☐F ☐G ☐N
Requested Effective Date:	Requested Effective Date:
Mail Policy To: ☐ Insured ☐ Agent	Mail Policy To: ☐ Insured ☐ Agent

SECTION 2: APPLICANT INFORMATION - PLEASE ANSWER ALL QUESTIONS COMPLETELY

APPLICANT	APPLICANT B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No.	Home Phone No.
E-mail Address	E-mail Address
Date of Birth: Current Age _____	Date of Birth: Current Age _____
☐ Male ☐ Female	☐ Male ☐ Female
Social Security No.	Social Security No.
Medicare Health Insurance Card Number	Medicare Health Insurance Card Number
Need not answer these 3 questions if eligible for Open Enrollment and/or Guaranteed Issue. Height / Weight: Ft. _____ In. _____ Lbs. _____ Have you used tobacco in any form, an electronic cigarette (e-cig) or other nicotine delivery product in the past 12 months? ..... ☐ Yes ☐ No Are you applying for coverage because you have been diagnosed or treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis? ..... ☐ Yes ☐ No	Need not answer these 3 questions if eligible for Open Enrollment and/or Guaranteed Issue. Height / Weight: Ft. _____ In. _____ Lbs. _____ Have you used tobacco in any form, an electronic cigarette (e-cig) or other nicotine delivery product in the past 12 months? ..... ☐ Yes ☐ No Are you applying for coverage because you have been diagnosed or treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis? ..... ☐ Yes ☐ No

SECTION 3: PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

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.

To the Best of Your Knowledge:	**Applicant**	**Applicant B**
1. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," what is your effective date? _____ (Applicant) / _____ (Applicant B)		
3. 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
4. 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 _____ (Applicant) END _____ START _____ (Applicant B) END _____		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(c) Did you drop a Medicare Supplement policy to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have another Medicare Supplement policy inforce?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If so, with what company and what do you have?		

APPLICANT	**APPLICANT B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date	Issue Date

	Applicant	**Applicant B**
(b) If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you had coverage under any health insurance within the past 63 days? (for example, an employer, union, or individual plan)	☐ Yes ☐ No	☐ Yes ☐ No
(a) If so, with what company and what kind of policy?		

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? (If you are still covered under this plan, leave "END" blank.)

START _____ (Applicant) END _____ START _____ (Applicant B) END _____

SECTION 4: PLEASE ANSWER ALL QUESTIONS COMPLETELY

To the Best of Your Knowledge:	**Applicant**	**Applicant B**
1. Are you covered under Medicare Part A?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part A effective date? _____ (Applicant) / _____ (Applicant B)		
If "NO," what is your eligibility date? _____ (Applicant) / _____ (Applicant B)		
2. Are you applying during a Guaranteed Issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 4: CONTINUED

	Applicant	Applicant B
3. Is your former Medicare Supplement or Medicare Select policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No
4. If you are replacing coverage have you received a copy of the replacement notice?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If replacing indicate termination date: _____ (Applicant) / _____ (Applicant B)		
5. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 5: BILLING INFORMATION

APPLICANT	APPLICANT B
Initial Premium (including enrollment fee)	Initial Premium (including enrollment fee)
$ _____ (Med Supp Premium) + $ _____ (Enrollment Fee) + $ _____ (Dental Premium) + $ _____ (Vision Premium) = $ _____ (Total)	$ _____ (Med Supp Premium) + $ _____ (Enrollment Fee) + $ _____ (Dental Premium) + $ _____ (Vision Premium) = $ _____ (Total)
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 #:

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.

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

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	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 member of the medical profession with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed by a member of the medical profession 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 member of the medical profession with or taken medication for Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been diagnosed by a member of the medical profession with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No	☐ Yes ☐ No
6. Within the past 24 months have you been treated by a member of the medical profession for or been advised by a 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 by a member of the medical profession for or been advised by a 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, Transcient Ischemic Attack (TIA) or heart rhythm disorder?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past 24 months have you been treated by a member of the medical profession for degenerative bone disease, crippling/disabling, Rheumatoid Arthritis, Spinal Stenosis or have you been advised by a member of the medical profession to have a joint replacement?	☐ Yes ☐ No	☐ Yes ☐ No
9. Has a physician advised you to have cataract surgery in the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
10. Has a 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 physician to have an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
13. At any time, have you been medically diagnosed with, treated by a member of the medical profession 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	

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: All sections of this application must be completed in order for us to process your application. 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)
☐ City in which you were born
☐ Name of first pet

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, 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. (Please see the following page for state-specific variations of this fraud notice.)

_____

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 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.

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 Licensed Producer) (Signature of Licensed Producer)

_____ _____
PRODUCER NUMBER/(STAMP) PRODUCER 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	Policy/Certificate 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	Policy/Certificate 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**

LEAVE WITH APPLICANT

FRAUD WARNING NOTICES: (If you live in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Alaska: Any 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.
Alabama/Arkansas/Louisiana/New Mexico/Rhode Island/West Virginia: 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.
Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
California: 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. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
Colorado: 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.
DC: It is a crime to provide false or misleading information to an 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.
Delaware/Idaho/Indiana: 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.
Florida: 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.
Georgia: A natural person convicted of a violation of insurance fraud shall be guilty of a felony and shall be punished by imprisonment for not less than two nor more than ten years, or by a fine of not more than ten thousand dollars, or both.
Hawaii: Any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.
Kansas: 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 material fact thereto, may be guilty of insurance fraud as determined by a court of law.
Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Maine/Tennessee/Washington: 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.
Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire: 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.
New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New York: 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.
Ohio: Any person who, with the 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 is guilty of insurance fraud.
Oklahoma: 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.
Oregon: 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.
Pennsylvania: 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.
Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia: ANY PERSON WHO, WITH THE 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 HAVE VIOLATED STATE LAW.

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, MIB, Inc., or anyone else 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, but not be limited to, 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

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 inforce. 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

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 inforce. 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

Renaissance
Life & Health Insurance Company of America

AGENT CERTIFICATION

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

Applicant: _____
Medicare Supplement

- ☐ **Plan A**
- ☐ **Plan B**
- ☐ **Plan C**
- ☐ **Plan F**
- ☐ **Plan G**
- ☐ **Plan N**

Applicant B: _____
Medicare Supplement

- ☐ **Plan A**
- ☐ **Plan B**
- ☐ **Plan C**
- ☐ **Plan F**
- ☐ **Plan G**
- ☐ **Plan N**

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

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. Write in your Dental/Vision plan's monthly premium from the Rate Sheet. Add the Medicare Supplement monthly payment and the Dental/Vision payment to determine total premium.	$128.52 $59.32 $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)	$187.84 Monthly Payment $563.52 Quarterly Payment $1,127.04 Semi-Annual Payment $2,254.08 Annual Payment		
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.	$187.84 + $25.00 = $212.84 Example shows initial payment (monthly schedule).		

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

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 +

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

Renaissance®
Life & Health Insurance Company of America

ACH FAX TRANSMITTAL GUIDE

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 _____

NOTES

Renaissance®
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.

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