



Eligibility Enrollment/Update

Social Security Number _____

Group Name _____

Group/Subgroup# _____

Plan Enrollment/Update Information (please indicate type of update and fill in appropriate information)

Type of Update: New Enrollment Reinstatement Change/Correction to Information Termination of Benefits

Group Transfer
From: Group/Subgroup# _____ To: Group/Subgroup# _____ Rate Code Change
From: _____ To: _____ Effective Date of Change _____ Change is for:
Subscriber
Dependent

Subscriber Information (please complete for all enrollments/updates)

First Name _____ MI _____ Last Name _____

Street Address _____ Check if New Address

City _____ State _____ ZIP Code _____

Status: Active COBRA Retiree Surviving

Birth Date _____ Date of Hire _____ Coverage Effective Date _____
MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY

Enrollment/Corrections to Information (please fill in for spouse/dependents for first-time enrollment or corrections)

SPOUSE
First Name _____ MI _____ Last Name if different _____

Birth Date _____ SSN _____ Status: Legal Surviving
MM/DD/YYYY

DEPENDENT #1
First Name _____ MI _____ Last Name if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Disabled
MM/DD/YYYY

DEPENDENT #2
First Name _____ MI _____ Last Name if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Disabled
MM/DD/YYYY

DEPENDENT #3
First Name _____ MI _____ Last Name if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Disabled
MM/DD/YYYY

DEPENDENT #4
First Name _____ MI _____ Last Name if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Disabled
MM/DD/YYYY

Employee Name _____ Employee ID _____

I request coverage under my employer's group insurance plan and authorize my employer to make deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim of an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature _____ Date _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Renaissance coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your group continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**

Surviving: The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Benefits: Check only if you are terminating Renaissance coverage for yourself or a family member.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

When changing a rate code, please refer to the following explanation to select the code that describes who is being covered by your Renaissance program.

Rate Codes:

- Rate 1 Employee Only
- Rate 2 Employee and spouse
- Rate 3 Employee, spouse and children
- Rate 5 Employee, one child, no spouse
- Rate 6 Employee and more than one child, no spouse

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Renaissance. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse

Surviving: The surviving spouse or child of a deceased subscriber.

IRS Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Disabled: Your permanently disabled child.