



Renaissance®

DENTAL · VISION · LIFE · DISABILITY

CLAIMS SUBMISSION FOR:
SHORT TERM DISABILITY (STD)

GROUP SHORT TERM DISABILITY ("STD") CLAIM FORM

-Please Print or Type in Dark Ink-

INSTRUCTIONS

To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays. This claim application requests information that is necessary for the quick and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

Ⓐ THERE ARE FOUR (4) PRIMARY SECTIONS TO BE COMPLETED IN THIS FORM:

- SECTION I: Authorization (to be completed by you, the employee)
- SECTION IA: Employee Statement
- SECTION II: Employer Statement
- SECTION III: Physician Statement

Ⓑ SEND COMPLETED FORM TO RENAISSANCE GROUP CLAIMS AT:

- **MAIL:** 2 Court Street, Suite 102, Binghamton, NY 13901
OR IF YOU HAVE ACCESS:
- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX TO:** 607-773-2276

Ⓒ IT IS THE RESPONSIBILITY OF YOU AND YOUR EMPLOYER TO INFORM US OF YOUR SCHEDULED OR ACTUAL RETURN TO WORK DATE AS SOON AS POSSIBLE.

Ⓓ PLEASE NOTE: IF AN OVERPAYMENT SHOULD OCCUR ON YOUR CLAIM, THE AMOUNT OF THE OVERPAYMENT MUST BE RETURNED TO US.

SECTION I | EMPLOYEE STATEMENT

Full Name (Last, First, MI): _____ Phone Number: _____

Social Security Number: _____ Male Female Date of Birth (mm/dd/yyyy): _____

Street Address (Include Apt#/Suite): _____ City: _____ State: _____ ZIP Code: _____

Employer Name: _____

Employee's Occupation and Duties (Please List Occupation Duties Below):

Date of Accident OR Date of First Symptoms (mm/dd/yyyy): _____ Last Date Worked (mm/dd/yyyy): _____

You Are Unable to Work Due To (Check One): Injury Illness Pregnancy

Date You Returned to Work (mm/dd/yyyy): _____ Full Time OR Part Time

If You Have Not Returned to Work, When Do You Expect to Return (mm/dd/yyyy)?: _____ Full Time OR Part Time

Describe In Detail, When, Where and How Accident Occurred, or Nature of Disability and First Symptoms:

Is Your Accident or Illness Related to Your Occupation?: Yes No If Yes, Explain:

Have You Filed a Workers' Compensation Claim?: Yes No (Please Explain Below) If No, Do You Intend To?: Yes No

Are You Receiving Any of the Following (Check Each Benefit You Are Receiving)?:

TYPE OF BENEFIT	AMOUNT	BEGIN DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)	TYPE OF BENEFIT	AMOUNT	BEGIN DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)
<input type="checkbox"/> Workers' Compensation	\$			<input type="checkbox"/> Unemployment	\$		
<input type="checkbox"/> Social Security	\$			<input type="checkbox"/> Other (Individual or Group)*	\$		
<input type="checkbox"/> State Disability	\$			<input type="checkbox"/> Auto Insurance Wage Replacement*	\$		
<input type="checkbox"/> Canadian Pension Plan	\$						

*IF YES, GIVE NAME AND ADDRESS OF INSURER BELOW:

Insurer Name(s) and Address (Include Apt#/Suite): _____ City: _____ State: _____ ZIP Code: _____

NOTE: IF CLAIM FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.

SECTION I | EMPLOYEE STATEMENT (CONTINUED)

When Were You First Treated For Your Illness or Accident (mm/dd/yyyy)?:	Name of Healthcare Provider(s) Consulted (Last, First, MI):
Date Consulted (mm/dd/yyyy):	Phone:
Name of Hospital(s):	Date Admitted (mm/dd/yyyy):
	Date Discharged (mm/dd/yyyy):
Have You Ever Had Same or Similar Condition In the Past?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List Name and Address of Hospital/Doctor Below:	
Name of Physician(s) Consulted and Date Consulted: Name (First Middle Last): Date Consulted (mm/dd/yyyy):	Date Admitted (mm/dd/yyyy):
	Date Discharged (mm/dd/yyyy):
Name of Hospital(s):	Date Admitted (mm/dd/yyyy):
	Date Discharged (mm/dd/yyyy):
If Benefits are Approved, do you want the minimum \$20.00 per week withheld from your check for Federal Income Tax purposes?: <input type="checkbox"/> Yes <input type="checkbox"/> No If you want more withheld, please state dollar amount you want withheld: \$	
BY SIGNING BELOW I AGREE THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
Employee Signature: <u>X</u>	Date Signed: _____
(Your Signature is Required for Benefit Consideration)	(mm/dd/yyyy)

NOTE: IF CLAIM FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.



SECTION IA | AUTHORIZATION AND DISCLOSURES TO:

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| <ul style="list-style-type: none"> • PHYSICIANS & OTHER HEALTH CARE PROFESSIONALS • CONSUMER REPORTING AGENCIES & CREDIT REPORT BUREAUS • EMPLOYERS • GROUP POLICYHOLDERS, CONTRACT HOLDERS/VENDORS, CLAIMS ADMINISTRATORS OR THEIR SUCCESSORS • GOVERNMENTAL AGENCIES (INCLUDING AND NOT LIMITED TO THE SOCIAL SECURITY ADMINISTRATION, VETERANS' ADMINISTRATION, RAILROAD RETIREMENT BOARD, JONES ACT ADMINISTRATION, AND STATE RETIREMENT SYSTEMS) | <ul style="list-style-type: none"> • HOSPITALS, CLINICS AND HEALTH CARE FACILITIES • INSURERS AND PRE-PAID HEALTH PLANS • PHARMACIES AND PHARMACY BENEFIT MANAGERS • STATE VOCATIONAL REHABILITATION AGENCIES AND OTHER PROVIDERS OF REHABILITATION SERVICES • MEDICAL INFORMATION BUREAU (MIB) OR OTHER COMPANIES, WHICH COLLECT HEALTH & INSURANCE INFORMATION • ATTORNEY REPRESENTATIVES |
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YOU ARE AUTHORIZED TO PROVIDE INFORMATION RELATED TO MY HEALTH CONDITION AND JOB MODIFICATIONS/ACCOMMODATIONS WITH MY CURRENT OR FUTURE EMPLOYER TO: (1) Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Company of New York (*Renaissance*); (2) The plan administrator or claim administrator of any benefit plan under which I may be a participant; or (3) Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim. **THIS INCLUDES, BUT IS NOT LIMITED TO, ANY:** (1) Records, test results, data, and information about health care history, diagnosis, prognosis, treatment, and supplies; (2) Employment-related information; (3) Income-related information; (4) Information from credit reporting bureaus or other consumer reporting agencies; or (5) Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (*hereinafter collectively referred to as "Information"*).

I UNDERSTAND THAT THE INFORMATION BEING DISCLOSED MAY INCLUDE PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AND ACCOMPANYING REGULATIONS (HIPAA), INFORMATION REGARDING MENTAL HEALTH CONDITIONS AND THE USE OF DRUGS OR ALCOHOL, AND INFORMATION REGARDING THE HUMAN IMMUNODEFICIENCY VIRUS (HIV).

I UNDERSTAND THAT THE INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING, MANAGING AND/OR ADMINISTERING BENEFITS FOR SHORT TERM DISABILITY, LONG TERM DISABILITY, SALARY CONTINUATION, WORKERS' COMPENSATION OR ANY OTHER BENEFIT PROGRAM OFFERED BY AND THROUGH THE EMPLOYER (HEREINAFTER COLLECTIVELY REFERRED TO AS "BENEFITS PROGRAM"), DEVELOPING A VOCATIONAL REHABILITATION PLAN, AND OTHER PURPOSES IN CONNECTION WITH THE ADMINISTRATION OF THE BENEFITS PROGRAM.

I FURTHER AUTHORIZE RE-DISCLOSURE OF ANY INFORMATION OBTAINED OR DEVELOPED IN THE COURSE OF MANAGING AND/OR ADMINISTERING THE BENEFITS PROGRAM TO THE PLAN ADMINISTRATOR OR CLAIM ADMINISTRATOR OF ANY BENEFITS PROGRAM UNDER WHICH I MAY BE A PARTICIPANT, CLAIMS INVESTIGATORS, ATTORNEYS, PHYSICIAN CONSULTANTS AND OTHER SERVICE PROVIDERS, INCLUDING TREATING PHYSICIAN(S), SOLELY FOR THE PURPOSE OF EVALUATING, ANALYZING, MANAGING AND/OR ADMINISTERING THE BENEFITS PROGRAM. I UNDERSTAND THAT INFORMATION RE-DISCLOSED PURSUANT TO THIS AUTHORIZATION WILL NO LONGER BE PROTECTED UNDER HIPAA. I UNDERSTAND THAT THIS AUTHORIZATION SHALL REMAIN IN FORCE FOR THE DURATION OF MY CLAIM FOR BENEFITS OR SUCH SHORTER PERIOD AS MANDATED BY APPLICABLE LAW. I ALSO UNDERSTAND THAT I HAVE THE RIGHT UPON REQUEST TO RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AND EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME BY MY GIVING WRITTEN NOTICE THAT IS SIGNED BY ME. I UNDERSTAND THAT ANY SUCH REVOCATION SHALL NOT APPLY TO ANY DISCLOSURE OR RE-DISCLOSURE OF INFORMATION MADE IN RELIANCE ON MY INITIAL AUTHORIZATION. I ALSO UNDERSTAND THAT MY FAILURE TO SIGN THIS AUTHORIZATION, OR MY SUBSEQUENT REVOCATION OF THIS AUTHORIZATION, MAY IMPAIR THE ABILITY OF RENAISSANCE TO PROCESS MY CLAIM AND MAY LEAD TO THE DENYING OR TERMINATING OF MY CLAIM FOR BENEFITS.

CLAIMANT	Full Name Printed: _____ D.O.B (mm/dd/yyyy): _____ Signature (Required): _____ Date Signed (mm/dd/yyyy): _____
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If the Insured is unable to sign, an authorized Representative May Sign Below For that Insured (*Please provide description of the representative's authority to sign below*): _____

AUTHORIZED REPRESENTATIVE	Full Name Printed: _____ Signature (Required): _____ Date Signed (mm/dd/yyyy): _____
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YOUR MEDICAL PROVIDER IS REQUIRED TO COMPLETE THE SECTION BELOW:

SECTION LLL | PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT ("MEDICAL PROVIDER")

Patient Name (Last, First, MI):		Date of Birth (mm/dd/yyyy):	
Patient Is/Was Unable to Work Due To (Check One): <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy			
Diagnosis (Include Complications and ICD 10):			
For Normal Pregnancy, Complete the Following Items, Then Skip to the "Dates of Disability" Below:			
Type of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	LMP Date (mm/dd/yyyy):	EXP. Date of Delivery (mm/dd/yyyy):	Actual Date of Delivery (mm/dd/yyyy):
When Did Symptoms First Appear or Accident Happen (mm/dd/yyyy)?:		Has Patient Ever Had Same or Similar Condition?: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, State When and Describe):	
Commencement Date of Disability (mm/dd/yyyy):			
Is Condition Due to Injury/Illness Arising Out of Patient's Employment?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of First Visit (mm/dd/yyyy):	Most Recent Visit (mm/dd/yyyy):	Next Scheduled Appointment (mm/dd/yyyy):	Frequency of Visits:
Nature of Treatment (Surgery, Medications, Etc.):		Names and Addresses of Other Physicians:	
Has Patient Been Hospitalized?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Name and Address:		From (mm/dd/yyyy): To (mm/dd/yyyy):	
Restrictions (What the Patient <u>SHOULD NOT</u> Do):		Limitations (What the Patient <u>CANNOT</u> Do):	
If Employer Can Accommodate Patient's Limitations And Restrictions, Is The Patient Able To Return To Work?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, What Date Could Employment Begin (mm/dd/yyyy): <input type="checkbox"/> Part Time <u>OR</u> <input type="checkbox"/> Full Time			
Dates of Total Disability: From: (mm/dd/yyyy): _____ To: (mm/dd/yyyy): _____			
Dates of Partial Disability: From: (mm/dd/yyyy): _____ To: (mm/dd/yyyy): _____			
Date Patient Able to Return to Work (mm/dd/yyyy): _____			
Print Name (Last, First, MI):			License Number:
Specialty:		Phone:	Tax ID:
Address (Include Apt#/Suite):		City:	State: ZIP Code:
BY SIGNING BELOW I AGREE THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.			
Medical Provider Signature (Required): <u>X</u>		Date Signed (mm/dd/yyyy): _____	
(Stamps Are Not Accepted)			

STATE FRAUD WARNING STATEMENTS:

The laws of the states beneath require the Company to provide the following statements:

- AL:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.
- AK:** A 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.
- AZ:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- AR, LA, RI and WV:** 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.
- CA:** For your protection, California law requires the following to appear on this form: 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.
- CO:** 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.
- CT:** 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.
- DE:** 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.
- DC:** WARNING: It is a crime to provide false or misleading information to any 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.
- FL:** 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.
- ID:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
- IN:** A person who knowingly and with intent to defraud a insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
- KY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
- MA:** 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 a denial of insurance benefits.
- MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ME:** 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 a denial of insurance benefits.
- MN:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- NH:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in NH R.S.A. REV Stat ANN 638.20.
- NJ:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- NM:** 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.
- NY:** 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.
- OH:** Any person who, with intent to defraud or knowing that he 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
- OK:** WARNING: 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. Penalties may include imprisonment, fines or a denial of insurance benefits.
- PA:** 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.
- TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.
- TX:** 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.
- VA, WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.



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Products Underwritten by Renaissance Life & Health Insurance Company of America and in New York by Renaissance Life & Health Insurance Company of New York



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