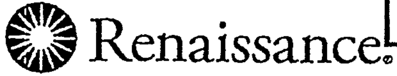
Please complete & mail to :
Council 82 Membership
63 Colvin Ave
Albany NY 12206



DENTAL · VISION · LIFE · DISABILITY

Renaissance Life & Health Insurance Company of New York
2 Court St. Binghamton, NY 13901
NEW YORK

RENAISSANCE EMPLOYEE ENROLLMENT FORM

—Please Type Or Print Clearly In Dark Ink—

SECTION I | EMPLOYER INFORMATION (Policyholder Use Only)

Name of Employer: Council 82 NYS Officers Union		Group ID Number: G000104048	Billing Class:
Local #, Name and Location		Policy Number(s):	
Date of Hire or Rehire:	Hours Worked Per Week:	Earnings: $ Per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other If Other Specify:	

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Re-enrollment ☐ Change in Status ☐ Other
If Other Specify: ___

SECTION II | EMPLOYEE INFORMATION (Completed By Applicant)

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	Email: Phone:	
Street Address *(Include Apt#/Suite)*:	City:	State:	ZIP Code:
Social Security Number:	Date of Birth *(mm/dd/yyyy)*:	Job Title/Occupation:	

SECTION II A | SPOUSE INFORMATION (If Applying For Benefits For Your Spouse - Complete Information Below)

Your ☐ Spouse *OR* ☐ Domestic Partner* *(Check One Box Only)*	Full Name *(Last, First, MI)*:	☐ Male ☐ Female	Date of Birth *(mm/dd/yyyy)*:	Social Security Number:
Street Address *(Include Apt#/Suite)*: ☐ *Check if same as above*		City:	State:	ZIP Code:

SECTION II B | CHILD(REN) INFORMATION (If Applying For Benefits For Your Dependent Child(Ren) - Complete Information Below)

Dependent's Name (Last, First, MI)	Male (M) Female (F)	Full-Time Student	Date of Birth (mm/dd/yyyy)	Social Security Number
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		

If more than three children are to be enrolled, include a separate list including the above information with this form

**This Employee Enrollment Form uses the term "Spouse" to refer to the person, either Spouse or Domestic Partner, for whom you are applying for benefits. If your Employer does not extend benefits to Domestic Partners and you are not enrolling a Spouse, leave this section blank.*

SECTION III | COVERAGE ELECTIONS

IF YOU SELECT "NO COVERAGE" BELOW, YOU ACKNOWLEDGE THAT YOU UNDERSTAND THAT IF YOU APPLY FOR COVERAGE AT A LATER DATE, YOU WILL BE CONSIDERED A LATE APPLICANT, YOU MAY BE SUBJECT TO WAITING PERIODS AND/OR REQUIRED TO FURNISH EVIDENCE OF INSURABILITY AT YOUR OWN EXPENSE, AND THAT RENAISSANCE WILL HAVE THE RIGHT TO REFUSE YOUR REQUEST.

If applying for Life or Disability insurance, please check with your Human Resources Department on coverage options and health information requirements.

A. TERM LIFE INSURANCE	EMPLOYEE	☑ Basic Life ☐ No Coverage ☐ Voluntary Life: Amount Electing: $________ OR ________x Base Annual Compensation
	SPOUSE	☐ Voluntary Life Amount Electing: $__________
	CHILD	☐ Voluntary Life Amount Electing: $__________
B. SHORT TERM DISABILITY (STD) INSURANCE	EMPLOYEE ONLY	☐ STD ☐ No Coverage ☐ Voluntary STD: % of Weekly Earnings: ______________%
C. LONG TERM DISABILITY (LTD) INSURANCE	EMPLOYEE ONLY	☐ LTD ☐ No Coverage ☐ Voluntary LTD: % of Weekly Earnings: ______________%

SECTION IV | BENEFICIARY (Completed Only if Life Coverages are Elected)

Full Name (First, Last, MI)	Mailing Address	Telephone Number	Relationship To You	Social Security Number	Percent

If you need more room, please request our Beneficiary form.

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

SECTION V | SIGNATURES

My signature on this Employee Enrollment Form further represents that:

I authorize my Employer's Payroll Department to deduct the required premium, if any, from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my Employer and Renaissance, and are to be paid to Renaissance when due.

I am applying for the coverages designated for which I am eligible under my Employer's plan with Renaissance and I understand that my dependents are not eligible for coverage if I am not enrolled. No coverages above the Guaranteed Issue Limit are effective until my completed Evidence of Insurability is approved by Renaissance. If I am applying as a Late Applicant, I understand that no coverage is effective until my completed Evidence of Insurability is approved by Renaissance and certain limitations and waiting periods may apply.

I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work. I also understand that dependent coverage will not become effective while the dependent is confined to the Hospital or otherwise unable to perform the duties of a person of like sex and age.

For any Life coverage for which I am applying, I designate the beneficiary(ies) named in the beneficiary section of this Employee Enrollment Form to receive any benefits payable in the event of my death.

THE EMPLOYEE ENROLLMENT FORM IS SUBJECT TO APPROVAL, REFUSAL OR MODIFICATION IN ACCORDANCE WITH RENAISSANCE GUIDELINES. MISREPRESENTATION WILL CAUSE THIS FORM AND SUBSEQUENT COVERAGE TO BE CONTESTED SUBJECT TO THE INCONTESTABILITY CLAUSE OF THE POLICY.

RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS AND MAY BE TAXABLE.

FRAUD WARNING (EXCLUDING LIFE INSURANCE): 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.

Employee's Date of Birth (MM/YYYY): ____________________

Applicant Signature (Required): ____ Date: ____________________

Spouse's Signature (If applying for coverage): ________________________________ Date: ____________________

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Renaissance.

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