Renaissance®
Life & Health Insurance Company of America

STANDARD MEDICARE SUPPLEMENT INSURANCE PLAN

DRAFT

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:

Make Sure all of this is attached before submission

☐ **Application for Standard Medicare Supplement** *(Form RENMEDCOMBO-UT 030716)*
- 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-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-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-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**

Make sure you leave this with the client

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

If Mailing Application use this address

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

If faxing the application please use this number

Renaissance®
Life & Health Insurance Company of America
Domicile State: Indiana
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 ☐ F ☐ G ☐ N	☐ A ☐ F ☐ G ☐ N
Requested Effective Date:	The effective, or draft date cannot be on the 29th, 30th or 31st of the month UW pg 13
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 _____	the exact age as of the application date Page 10 of UW Date of Birth: Current Age _____
☐ Male ☐ Female	☐ Male ☐ Female
Social Security No.	Social Security No.
Medicare Health Insurance Card Number	This is their Medicare Number Medicare Health Insurance Card Number
Height / Weight: Ft. _____ In. _____ Lbs. _____	Height and Weight Chart UW pg 12 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	Tobacco Chart per State UW pg 11 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	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 COMPLETELY

	Applicant	Applicant B
Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**?	☐ Yes ☐ No	☐ Yes ☐ No
To the Best of Your Knowledge:		
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 covered under Medicare Part B or have you enrolled in Medicare Part B in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part B effective date? _____ (Applicant) / _____ (Applicant B)		
If "NO," indicate date you plan to enroll. _____ (Applicant) / _____ (Applicant B)		
3. Have you turned 65 in the last six months or will you turn 65 within the next six months?	☐ 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.

These two things go together. If the Client is losing group coverage.

SECTION 4: FOR YOUR PROTECTION, th[illegible] 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.

	Applicant	Applicant B
To the Best of Your Knowledge:		
1. Are you applying during a guaranteed issue period?	☐ Yes ☐ No	☐ Yes ☐ No
(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 inforce?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company and what plan 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 "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date: _____ (Applicant) / _____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	☐ 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 _____ (Applicant) END _____ START _____ (Applicant B) END _____

Only answer the sub questions if question 3 applies to you

	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?	☐ Yes ☐ No	☐ Yes ☐ No
(b) **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No
(c) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(d) Did you drop a Medicare Supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(e) Is your former Medicare Supplement or Medicare Select policy/certificate still available?	☐ 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

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

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)
$ _____ (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: HOUSEHOLD PREMIUM DISCOUNT INFORMATION

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.	**Applicant**	**Applicant B**
1. Do you currently have a household resident (at least one, no more than 3) who is age 50 or older: a. with whom you have continuously resided for the past 12 months, or to whom you are either married or with whom you are in a civil union partnership; or	☐ Yes ☐ No	☐ Yes ☐ No
b. Who has an existing Medicare Supplement policy, or is applying for such a policy, with Renaissance Life & Health Insurance Company of America?	☐ Yes ☐ No	☐ Yes ☐ No
2. If you answered "YES" to Question 1a or 1b above, please fill out the following information about the household resident, except if both applicants are applying for coverage on this application.		

This is an easy way to see the rules on Household discount ☐ ☐ ☐

Name (First/Middle/Last):		
Policy Number:	Social Security Number:	Date of Birth:
Name (First/Middle/Last):		
Policy Number:	Social Security Number:	Date of Birth:

SECTION 7:

- **During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 7 and GO TO SECTION 8.**
- **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 with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed 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 with or taken medication for Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been diagnosed with or treated 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 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 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 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 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 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	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

ADDITIONAL INFORMATION: PART 7- 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

Decline Conditions List UW pg 19-21

Uninsurable Health Conditions

Applications should not be submitted if the applicant has ***any history*** of the following conditions:

AIDS	Chronic protein loss in the urine (proteinuria) requiring 4 or more MD office visits per year in the follow-up of renal disease.
Alzheimer's Disease	Chronic Renal Insufficiency
ARC	Hypertensive Chronic Renal Disease
Any cardio-pulmonary disorder requiring oxygen	Nephrotic Syndrome
Cirrhosis	Diabetes - Insulin > 50 units / day
Chronic Hepatitis:	Diabetes with history of high blood pressure, taking more than 2 diabetes medications and or more than 2 high blood pressure medications.
Chronic Hepatitis B	Diabetes with complications such as neuropathy or retinopathy or kidney disease, heart or vascular disease, TIA or stroke.
Chronic Hepatitis C	
Chronic Hepatitis D	Dementia, including delirium, organic brain disorder or other cognitive impairment.
Autoimmune Hepatitis	
Chronic Active Hepatitis	Emphysema
Chronic Steatohepatitis	HIV
Chronic Obstructive Pulmonary Disease (COPD)	Kidney Disease requiring dialysis
Other chronic pulmonary disorders to include:	Kidney Failure/End Stage Renal Disease (ESRD) or any kidney disorder that the applicant is being evaluated for or if the applicant is currently on dialysis.
Asbestosis	Lateral Sclerosis (ALS)
Bronchiectasis	Lupus - Systemic
Chronic bronchitis	Multiple Sclerosis
Chronic Cardiopulmonary Disease	Myasthenia Gravis
Chronic Obstructive Lung Disease (COLD)	Organ transplant
Chronic asthma*	Osteoporosis with fracture
Chronic interstitial lung disease	Parkinson's Disease
Chronic pulmonary fibrosis	Pulmonary Hypertension
Cystic Fibrosis	Rheumatoid Arthritis treated with injectable medications or Methotrexate and Prednisone or more than 25 mg Methotrexate per week
Chronic Kidney/Renal Disease:	Sarcoidosis
Chronic Nephritis	Scleroderma
Chronic Glomerulonephritis	

In addition to the above conditions, the following will also lead to a decline:

- Implantable cardiac defibrillator.
- Use of supplemental oxygen.
- Use of a nebulizer.
- *Asthma requiring continuous use of three or more medication's, including inhalers.
- Taking any medication that must be administered in a physician's office.
- Advised to have surgery, medical tests, treatment or therapy.

Partial List of Medications Associated with Uninsurable Health Conditions

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications (brand or generic):

Medication	Condition	Medication	Condition
3TC	AIDS	**Geodon**	Schizophrenia
Acetate	Prostate Cancer	**Gold**	Rheumatoid Arthritis
Alkeran	Cancer	**Haldol**	Psychosis
Amantadine	Parkinson's Disease	**Herceptin**	Cancer
Apokyn	Parkinson's Disease	**Hydergine**	Dementia
Aptivus	HIV	**Hydrea**	Cancer
Aricept	Dementia	**Hydroxyurea**	Melanoma, Leukemia, Cancer
Artane	Parkinson's Disease	**Imuran**	Immunosupression, Severe Arthritis
Atripla	HIV	***Insulin (>50 units/day)**	Diabetes
Avonex	Multiple Sclerosis	**Interferon**	AIDS, Cancer, Hepatitis
Azilect	Parkinson's Disease	**Indinavir**	AIDS
AZT	AIDS	**Invega**	Schizophrenia
Baclofen	Multiple Sclerosis	**Invirase**	AIDS
BCG	Bladder Cancer	**Kaletra**	AIDS
Betaseron	Multiple Sclerosis	**Kemadrin**	Parkinson's Disease
Bicalutamide	Prostate Cancer	**Lasix/Furosemide**	Heart Disease
Breo	COPD	**(>60 mg/day)**	
Brovana	COPD	**L-Dopa**	Parkinson's Disease
Carbidopa	Parkinson's Disease	**Letairis**	Pulmonary Hypertension
Casodex	Prostate Cancer	**Leukeran**	Cancer, Immunosupression, Severe Arthritis
Cerefolin	Dementia	**Leuprolide**	Prostate Cancer
Cogentin	Parkinson's Disease	**Levodopa**	Parkinson's Disease
Cognex	Dementia	**Lexiva**	HIV
Combivir	HIV	**Lioresal**	Multiple Sclerosis
Comtan	Parkinson's Disease	**Lomustine**	Cancer
Copaxone	Multiple Sclerosis	**Lupron**	Cancer
Crixivan	HIV	**Megace**	Cancer
Cytoxan	Cancer, Severe Arthritis, Immunosupression	**Megestrol**	Cancer
D4T	AIDS	**Mellaril**	Psychosis
DDC	AIDS	**Melphalan**	Cancer
DDI	AIDS	**Memantine**	Alzheimer's Disease
DES	Cancer	**Methotrexate (>25mg/wk)**	Rheumatoid Arthritis
Donepezil	Dementia/Alzheimer's	**Metrifonate**	Dementia
DuoNeb	COPD	**Mirapex**	Parkinson's Disease
Eldepryl	Parkinson's Disease	**Myleran**	Cancer
Eligard	Prostate Cancer	**Namenda**	Alzheimer's
Embrel	Rheumatoid Arthritis	**Natrecor**	CHF
Emtriva	HIV	**Navane**	Psychosis
Epivir	HIV	**Nelfinavir**	AIDS
Epogen	Kidney Failure, AIDS	**Neoral**	Immunosupression, Severe Arthritis
Ergoloid	Dementia	**Neupro**	Parkinson's Disease
Exelon	Dementia	**Norvir**	HIV
Fuzeon	HIV	**Novatrone**	Multiple Sclerosis
Galantamine	Dementia	**Paraplatin**	Cancer

Partial List of Medications Associated with Uninsurable Health Conditions (continued)

Medication	Condition	Medication	Condition
Parlodel	Parkinson's Disease	**Trizivir**	HIV
Permax	Parkinson's Disease	**Truvada**	HIV
Prednisone (>10 mg/ day)	Rheumatoid Arthritis, COPD	**Tysabri**	Multiple Sclerosis
Prezista	HIV	**Valycte**	CMV HIV
Procrit	Kidney Failure, AIDS	**VePesid**	Cancer
Prolixin	Psychosis	**Videx**	HIV
Provenge	Prostate Cancer	**Vincristine**	Cancer
Razadyne	Dementia	**Viracept**	HIV
Rebif	Parkinson's Diease	**Viramune**	AIDS
Remicade	Rheumadtoid Arthritis	**Viread**	HIV
Reminyl	Dementia	**Zanosar**	Cancer
Remodulin	Pulmonary Hypertension	**Zelapar**	Parkinson's Disease
Requip	Parkinson's Diease	**Zerit**	HIV
Rescriptor	HIV	**Ziagen**	HIV
Retrovir	AIDS	**Ziprasidone**	Schizophrenia
Reyataz	HIV	**Zoladex**	Cancer
Rilutek	Amyotrophic Lateral Sclerosis	**Zometa**	Hypercalcemia in Cancer
Riluzole	ALS		
Risperdal	Psychosis		
Ritonavir	AIDS		
Sandimmune	Immunosupression, Severe Arthritis		
Selzentry	HIV		
Sinemet	Parkinson's Disease		
Stalevo	Parkinson's Disease		
Stelazine	Psychosis		
Sustiva	AIDS		
Symmetrel	Parkinson's Disease		
Tacrine	Dementia		
Tasmar	Parkinsons' Disease		
Teslac	Cancer		
Thiotepa	Cancer		
Thorazine	Psychosis		
Trelstar-LA	Prostate Cancer		

SECTION 8: 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 9: 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 coveredby 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 10: 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

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 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

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 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 F**
- ☐ **Plan G**
- ☐ **Plan N**

Applicant B: _____
Medicare Supplement

- ☐ **Plan A**
- ☐ **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

Renaissance
Life & Health Insurance Company of America

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

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

RENMEDCOMBOCALC-OT 040516

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