

SERFF Tracking Number: RENA-126164725 State: Arkansas  
 Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 42487  
 Company Tracking Number:  
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental  
 Product Name: AR - Delta/Ren Application Open Enrollment  
 Project Name/Number: /

## Filing at a Glance

Company: Renaissance Life & Health Insurance Company of America

Product Name: AR - Delta/Ren Application Open Enrollment SERFF Tr Num: RENA-126164725 State: ArkansasLH

TOI: H10I Individual Health - Dental	SERFF Status: Closed	State Tr Num: 42487
Sub-TOI: H10I.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Veta Daniel, Claudia Niemara, Bryan Crips, Denise Chadwell, Kristen Schrauben, Robert Bess, Errick Phillips	Disposition Date: 05/29/2009
	Date Submitted: 05/26/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/29/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/29/2009
Deemer Date:	Corresponding Filing Tracking Number:
Filing Description:	
RE: Renaissance Life & Health Insurance Company of America, NAIC# 61700	
SERFF Tracking Number: RENA-126164725	

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On behalf of Renaissance Life & Health Insurance Company of America, I am enclosing for filing a revised Individual Dental Enrollment/Update form INVD-103A-Delta v2. This Form will be used in conjunction with individual dental Policy INVD-100A-Delta. This Form will replace the previous Form that was submitted under SERFF Tracking Number FRCS-125126900 and approved 6/29/2007. All other Forms remain unchanged and active.

Should you have any questions, please contact me at (517)381-4229 or bcrips@renaissancefamily.com.

Sincerely,

Bryan Joseph Crips  
 Administrative Analyst

## Company and Contact

### Filing Contact Information

Bryan Crips, Administrative Analyst bcrips@renaissancefamily.com  
 P.O. Box 30381 (517) 381-4229 [Phone]  
 Okemos, MI 48909-7881 (517) 347-5433[FAX]

### Filing Company Information

Renaissance Life & Health Insurance Company CoCode: 61700 State of Domicile: Delaware  
 of America  
 Group Code: 477 Company Type: Life & Health  
 P.O. Box 30381  
 Lansing, MI 48909-7881 Group Name: State ID Number:  
 (800) 745-7509 ext. [Phone] FEIN Number: 47-0397286  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? Yes  
 Fee Explanation: Application Form Filed Separately = \$20.00  
 Per Company: No

SERFF Tracking Number: RENA-126164725 State: Arkansas  
Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 42487  
of America  
Company Tracking Number:  
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: AR - Delta/Ren Application Open Enrollment  
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Renaissance Life & Health Insurance Company of America	\$20.00	05/26/2009	28094725

SERFF Tracking Number: RENA-126164725 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/29/2009	05/29/2009

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## Disposition

Disposition Date: 05/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: RENA-126164725 State: Arkansas

Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 42487

Company Tracking Number:

TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Individual Dental Enrollment/Update	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	INVD-103A-Delta v2	Application/Individual Enrollment Form	Dental Enrollment/Update	Revised	Replaced Form #: INVD-103A-Delta Previous Filing #: FRCS-125126900	43	Delta Ind. Enrollment Form V2 11-08.pdf



# Individual Dental Enrollment/Update

Enroll on line now at [mysmilecoverage.com](http://mysmilecoverage.com) using [access code 1295] or complete this form and mail to:  
Delta Dental Plan of Michigan, Inc.

Drawer #1752  
P.O. Box 79001  
Detroit, MI 48279-1752

If you have any questions about filling out this form, please contact our Customer Service department at (800) 971-4108.

- New Enrollment—Check for first-time enrollment for yourself or your spouse.
- Change/Correction to Information—Check if any changes are being submitted on this form.
- Termination of Benefits—Check only if you are terminating coverage for yourself or your spouse.

## [Region 2 CA,CO,MD,MI,MN,NH,RI,WI]

Will this policy replace or change any existing policy of health insurance?  Yes  No

If yes, please describe: \_\_\_\_\_

(This section must be completed for us to process your enrollment or update your records. Please print clearly or type.)

Enrollee Name		Example	A B C D E F 1 2 3 4 5 6
(First)	(M.I.)	(Last)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Birth Date	Sex	Enrollee Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Street Address			<input type="checkbox"/> Check here if this is a new address
<input type="text"/>			
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	
E-mail Address (Optional)		Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Coverage Effective Date			
<input type="text"/> - <input type="text"/> - <input type="text"/> [Access Code: 1295]			
(date coverage takes effect for you and/or your spouse)			

**Spouse Information** (Please complete this section if you are enrolling your spouse for the first time or if you have checked Change/Correction above and are changing information about your spouse that was previously submitted. You must include your spouse's first and last names.)

Spouse Name (First)		(M.I.)	(Last)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Birth Date	Sex	Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	

**Payment Information** (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):

	Rates:	
	Single	Two Person
	Monthly/Annual	Monthly/Annual
<input type="checkbox"/> Option I – PPO (Point of Service) – High Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxxx.xx]
<input type="checkbox"/> Option II – PPO (Standard) – Low Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxx.xx]

**Payment Frequency:**

- Annual (If you are paying by check, you **must** choose this option and pay the amount due in full)
- Monthly (If you are paying by credit card or automatic withdrawal, you may choose this option)



**Fraud Warning Notices:** (If the proposed insured or owner lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

**Arkansas/Louisiana/New/Mexico:** 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.

**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 certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder 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 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.

**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.

**Kentucky/Ohio:** I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

**Maine:** 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.

**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.

**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.

**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 omits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**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 include imprisonment, fines and denial of insurance benefits.

**Required California Notice:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

\_\_\_\_\_(Owner's Initials)





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## Supporting Document Schedules

**Bypassed -Name:** Flesch Certification **Review Status:** Approved-Closed 05/29/2009  
**Bypass Reason:** NA Does not apply to Filing only Application Enrollment Form  
**Comments:**

**Satisfied -Name:** Application **Review Status:** Approved-Closed 05/29/2009  
**Comments:**  
**Attachment:**  
Delta Ind. Enrollment Form V2 11-08.pdf

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 05/29/2009  
**Bypass Reason:** Does Not Apply  
**Comments:**



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## [Region 2 CA,CO,MD,MI,MN,NH,RI,WI]

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If yes, please describe: \_\_\_\_\_

(This section must be completed for us to process your enrollment or update your records. Please print clearly or type.)

Enrollee Name		Example	A B C D E F 1 2 3 4 5 6
(First)	(M.I.)	(Last)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Birth Date	Sex	Enrollee Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Street Address			<input type="checkbox"/> Check here if this is a new address
<input type="text"/>			
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	
E-mail Address (Optional)		Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Coverage Effective Date			
<input type="text"/> - <input type="text"/> - <input type="text"/> [Access Code: 1295]			
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Birth Date	Sex	Social Security Number	
<input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	

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	Monthly/Annual	Monthly/Annual
<input type="checkbox"/> Option I – PPO (Point of Service) – High Option	[\$xx.xx/\$xxx.xx]	[\$xx.xx/\$xxxx.xx]
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