



Unified Life Insurance Company
 P. O. Box 25326
 Overland Park, Kansas 66225-5326

RESI-DENT
APPLICATION FOR LIMITED BENEFIT DENTAL POLICY

A. APPLICANT (person who receives dental care)

Name: _____ O Male O Female
 Social Security Number: _____--____--_____ Date of Birth: ____/____/____
 Medicaid: O Yes O No Medicaid Number: _____

B. APPLICANT OR RESPONSIBLE PARTY

Name: _____ Relationship: _____
 Address: _____ Phone:(Day):_____ (Night):_____
 City: _____ State: _____ Zip: _____

C. FACILITY WHERE APPLICANT RESIDES

Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

D. MONTHLY PREMIUM \$ _____

E. AUTHORIZATION

I understand that coverage will not be effective until this application has been received, accepted, and evidence of coverage has been issued by Unified Life Insurance Company (hereafter called Company). I authorize any dentist to provide to the Company, its agents, employees, affiliates, designees, or its administrators involved in the evaluating, determining, or administrating benefits; information concerning advice, care or treatment provided under any policy issued upon this application. I further warrant that if I am not the Applicant that I have been appointed by a court of competent jurisdiction to represent the Applicant's interests and that I am fully empowered to sign this application on behalf of the Applicant and to authorize the release of the Applicant's medical records. I further acknowledge and agree that this information may be submitted to the appropriate state Medicaid agency for purposes of the facility listed above receiving reimbursement for the premiums. I hereby authorize the responsible DDS or any licensed dentist or hygienist designated by the DDS to perform the initial examination, dental prosthesis (denture) cleaning or oral prophylaxis (teeth) cleaning.

 Signature of Applicant or Responsible Party Date

F. AUTO-PAYMENT AUTHORIZATION

I hereby authorize the Company to initiate debit entries to my checking account at the bank indicated on the attached void check which is made part of this application. This authorization is to remain in full force and effect until the Company and bank have received written notification from me of its termination.

 Auto-Payment Authorization Signature Date

ATTACH VOIDED CHECK FOR AUTO-PAYMENT

FOR OFFICE USE ONLY Plan ID#: _____
 Beginning Effective Date: ____/____/____ Policy #: _____