

APPLICATION FOR DENTAL COVERAGE

COMPLETED APPLICATION TO BE RETURNED TO: **Resi-Dent**
8500 W 110th St., Suite 450 • Overland Park, KS 66210 • Phone: (913) 362-1112 Fax: (913) 362-1118
Out of Area: (888) 384-8996

A. PROPOSED SUBSCRIBER (person who receives dental care)

Name: _____ Male Female
Social Security Number: _____ -- _____ -- _____ Date of Birth: ____ / ____ / ____
Medicaid Number: _____

B. RESPONSIBLE PARTY (person, if other than subscriber, who is signing application on behalf of the subscriber)

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

C. METHOD OF PAYMENT (entity or person remitting premium payment on behalf of the proposed subscriber)

Monthly: \$60.00 Send bill to: Responsible Party Facility

D. FACILITY WHERE PROPOSED SUBSCRIBER RESIDES

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

E. APPLICATION SIGNATURE

I understand that coverage will not be effective until this application and applicable payment has been received, accepted, and evidence of coverage has been issued by the Company.

I authorize any dentist to provide to the Company, it's agents, employees, affiliates, designees, or it's administrators involved in evaluating, determining, or administering benefits, information concerning advice, care, or treatment provided under any policy issued upon this application. In addition, this application or a copy is my request and authorization for necessary diagnostic and preventive treatment as well as repair or adjustment of prosthodontics.

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSE OR BENEFIT KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO A FINE AND CONFINEMENT IN PRISON.

Is the policy, if issued, intended to replace any other accident or sickness insurance presently in force? Yes No

SUBSCRIBER or RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____ 

AGENT'S SIGNATURE: _____ DATE: _____ **Required**

F. Auto-Payment Authorization

I (We) hereby authorize National Dental Care Inc or it's authorized administrator to initiate debit entries to my (our) 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 COMPANY and BANK has received written notification from me (or either of us) of its termination.

AUTO-PAYMENT AUTHORIZATION SIGNATURE: _____ DATE: _____

Include Voided Check for Auto-Payment


Recommended

FOR OFFICE USE ONLY Plan ID#: _____ Beginning Effective: _____
POLICY #: _____ (Social Security Number) County: _____