

FOR OFFICE USE ONLY: Policy No. _____ Effective Date _____

Administered by: Forrest T. Jones & Company, Inc.
P. O. Box 418131
Kansas City, MO 64141

AccessCare General, LLC
8500 W. 110th St., Ste. 450, Overland Park, KS 66210 (888) 384-8996

Resi-Dent™

APPLICATION FOR LIMITED BENEFIT IN-FACILITY DENTAL POLICY

A. APPLICANT (person who receives dental care)

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

B. RESPONSIBLE PARTY

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

C. FACILITY WHERE APPLICANT RESIDES

Name of Facility: _____ Phone No. _____
Address: _____ City: _____ State: _____ Zip: _____

D. PREMIUM

Monthly Premium: \$60.00
Send bill to: Facility (on behalf of Applicant)
 Responsible Party (Direct Bill)

E. AUTHORIZATION

I understand that coverage will be provided for specified dental services rendered by a DDS, licensed dentist or hygienist inside the Applicant's Living Facility only. I also understand that coverage will not be effective until this application and applicable payment have been received and accepted, and evidence of coverage has been issued by AccessCare General, LLC (Company). I authorize any dentist to provide to the Company, its agents, employees, affiliates, designees, or its administrators involved in evaluating, determining, or administering benefits, information concerning advice, care, or treatment provided under any policy issued upon this application. For the purpose of evaluating, determining or administering benefits under the Policy, I further warrant that if I am not the Applicant that I am the Responsible Party who is responsible for making the Applicant's health care decisions and that I am fully empowered to sign this application on behalf of the Applicant and to authorize release of the Applicant's medical records. I further acknowledge and agree that this application may be submitted to the appropriate state Medicaid agency for purposes of the facility listed above receiving reimbursement for the premiums. I understand this authorization is valid for the term of coverage of the Policy.

I am aware that the Company may terminate this insurance at the end of any period for which the premium has been paid.

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 as determined by a court of law.

APPLICANT/RESPONSIBLE PARTY SIGNATURE _____ DATE: _____
Agent's Signature _____ Agent's Name _____

ACG-KS

I hereby authorize the Company to assign the benefits under this Policy to my dentist for the services rendered to the extent that these benefits have not been previously paid.

APPLICANT/RESPONSIBLE PARTY SIGNATURE _____ DATE: _____