

Underwritten by:
FIDELITY SECURITY LIFE INSURANCE COMPANY
 3130 Broadway • Kansas City, MO 64111

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: <input type="checkbox"/> Facility (on behalf of Applicant) <input type="checkbox"/> Responsible Party (Direct Bill)
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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 Fidelity Security Life Insurance Company (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. 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 may revoke this authorization at any time by providing written notice to Fidelity Security Life Insurance Company of my intent to revoke this authorization.

Is this coverage intended to replace or change any existing Dental coverage? Yes No

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

WARNING: 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.

DATE:
 APPLICANT/RESPONSIBLE PARTY SIGNATURE

Agent's Signature Agent's Name

