

**FOR OFFICE USE ONLY:** Plan ID# \_\_\_\_\_ Effective Date \_\_\_\_\_ Policy No. DT-219

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:  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 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.

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

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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: \_\_\_\_\_