

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 am aware that the Company may terminate this insurance at the end of any period for which the premium has been paid.  
 Is this coverage intended to replace or change any existing Dental coverage?  Yes  No

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 is guilty of insurance fraud.

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

## PAYMENT METHOD AUTHORIZATION

Please indicate which method of payment you will be paying your monthly dental insurance premium by checking the appropriate box, completing the bank information (if applicable), sign and date in the appropriate section and return to the address shown below.

### A. INVOICE TO FACILITY – TRUST ACCOUNT PAYMENT

- If the Facility receives the Social Security Benefits of your loved one and you wish to have the monthly premium paid by the Facility from the Trust Account please check the box to the left of this option and sign and date below.

▶ \_\_\_\_\_  
Signature of Applicant/Responsible Party \_\_\_\_\_  
Date

### B. INVOICE TO RESPONSIBLE PARTY – PAY BY CHECK

- If you receive the Social Security Benefits of your loved one and you wish to have the monthly premium invoice mailed to your home, check the box to the left of this option and sign and date below.

▶ \_\_\_\_\_  
Signature of Applicant/Responsible Party \_\_\_\_\_  
Date

### C. INVOICE TO RESPONSIBLE PARTY – AUTO PAY FROM CHECKING OR SAVINGS ACCOUNT

- If you wish to have the monthly premium automatically deducted from your Checking or Savings Account, check the box to the left of this option and complete the following authorization information and sign and date the authorization below in this section.

I hereby authorize Fidelity Security Life Insurance Company or its authorized administrator and the bank named below to initiate monthly debit entries for the premium to my  Checking  Savings account indicated below.

Bank Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Transit / ABA No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
(please call your bank if you do not know this number.)

**Attach Voided Check for Checking/Savings Account Auto-Payment**

By signing I authorize the debiting of my checking or savings account for the dental premium. This authorization is to remain in full force and effect until written notification from me of termination of the authorization has been received in such time and manner as to afford Fidelity Security Life Insurance Company or its authorized Administrator a reasonable opportunity to act on it.

▶ \_\_\_\_\_  
Signature of Account Holder \_\_\_\_\_  
Date

**Resi-Dent™ is a product of MobileCare2U, LLC**

**Please return the completed application to the agent:**

**MobileCare2U  
8500 W. 110<sup>th</sup> Street, Suite 450  
Overland Park, KS 66210**