

FOR OFFICE USE ONLY: Plan ID# _____ Effective Date _____ Policy No. _____

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

A-01095TX

M-9102TX

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.

▶ _____ DATE: _____
APPLICANT/RESPONSIBLE PARTY SIGNATURE