We are pleased to offer on-site, convenient dental services provided by the Resi-Dent dental program. Whether your loved one has their natural teeth or dentures, having good oral care is vital to overall health and well-being.

Resi-Dent provides an on-site dental environment with the following services:

- **Annual Exams**
- **New Dentures (Full or Partial)**
- **Emergency Response and Treatment**
- **Existing Denture Maintenance**
- **Teeth and Denture cleanings**
- **Fillings, Simple Extractions and X-rays**

HOW DOES THIS WORK FOR THOSE WHO ARE ON MEDICAID?

Enrolling in the program reduces what you pay to the facility by the amount of the monthly ($74) premium. You would then use that same amount to pay the premium. **If your loved one's social security check goes directly to the facility, then the facility will handle the billing for you. All you have to do is sign the application.**

Either way, this program will not affect your personal allowance and the facility is reimbursed.

This is a great way for Medicaid residents to use their social security income to receive dental care at NO ADDITIONAL COST.

HOW DOES THIS WORK FOR THOSE WHO ARE PRIVATE PAY?

Resi-Dent is an insurance plan that is available for the monthly premium of $74. There are no co-pays or deductibles. You may also have your loved one seen on a fee for service basis. Please contact Resi-Dent for a schedule of fees.

By choosing Resi-Dent, your loved one receives excellent dental care from a professional experienced in working with long term care patients.

We hope you take advantage of this service for your loved one. You may reach Resi-Dent at their toll-free number, 1-888-384-8996 or call our local representative, Shellie Wallace at 314-256-9266.

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

AccessCare General, LLC

8500 W. 110th St., Ste. 450, Overland Park, KS 66210 (877) 647-7948

APPLICATION FOR LIMITED BENEFIT IN-FACILITY DENTAL POLICY

A. APPLICANT (person who receives dental care)

Name: ______________________________ ☐ Male ☐ Female

Social Security Number: ______ - ____ - ______ Date of Birth: ______/______/______

Medicare: ☐ Yes ☐ No Medicare #: __________ Medicaid: ☐ Yes ☐ No Medicaid #: __________

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 (check one)

☐ Resi-Dent Basic (D13MOB) $45.00/month

☐ Resi-Dent Complete (D13MOC) $76.00/month

☐ Resi-Dent Plus (D13MOP) $120.00/month

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. 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. 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.

<u>I understand that some services covered by this policy may be covered by Medicaid, either directly or indirectly, and I elect this private policy.</u>

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.

▶ ______________________________ DATE: ______________

APPLICANT/RESPONSIBLE PARTY SIGNATURE

______________________________ ______________________________

Agent's Signature Agent's Name