KANSAS CITY LIFE INSURANCE COMPANY

32dental

Voluntary Low Plan

Covered Services *(Pay up to $750 Annual Benefit for Certain Procedures)*

Features Include:

- $50 deductible for Basic Services; $150 maximum deductible per family
- $750 annual maximum
- Toll-free Claims Hotline (800) 342-3279

This is not a certificate of insurance. It is a brief description only. The Group Policy alone determines all rights and benefits. Kansas City Life reserves the right to withdraw this offer at any time.

TYPE I
Preventive Services

- **100% coinsurance**
- **$0 individual deductible***
- **$0 family deductible***
- **No benefit waiting period**

- Routine Exams *
- Bitewing X-rays (Two sets per 12 months (4 x-rays)
- X-rays (One complete series per 36 months)
- Prophylaxis (cleaning) *
- Sealants ** (to age 16)
- Fluoride Treatment *** (to age 16)
- Space Maintainers (to age 14)
- Periodontal Maintenance

* 2 per calendar year
** Any 36 month period
*** 1 per calendar year

TYPE II
Basic Services

- **80% coinsurance**
- **$50 individual deductible***
- **$150 family deductible***
- **No benefit waiting period**

- Restorative (amalgam and composite fillings)
- Oral Surgery (extractions)
- Emergency Palliative Treatment

**Deductible is per calendar year.*

Rates* for
COUNTY OF VICTORIA

$18.96 Employee Only
$52.98 Employee + Family

**rates based on 12 pay periods per year.*

KANSAS CITY LIFE INSURANCE COMPANY — Group Dental Insurance Enrollment Card

Name of Employer: **COUNTY OF VICTORIA** — Group No.: **NV6**

Employee Name: First / Middle / Last — ☐ Female ☐ Male — Social Security Number

Home Address: Street / City / State / Zip — Date of Birth — Marital Status: ☐ Single ☐ Married

Date of Employment — Occupation — If COBRA continues please give: Qualifying Event, Date of Event — Work at least 30 hours per week? ☐ Yes ☐ No

Beneficiaries Full Name — Relationship

Check One: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee and Family

List Name, Sex, and Date of Birth of each Dependent You Wish to Insure.

Name	Sex	Date of Birth	Name	Sex	Date of Birth

Spouse's Dental Carrier: ☐ None — ☐ I authorize my employer to deduct from my earnings the amount to cover my share of the contribution for coverage indicated above.

Signature of Employee — Date — Office Use Only

GA 106