KANSAS CITY LIFE

GROUP BENEFITS

Kansas City Life Dental Alliance Nomination Form

I would like to nominate my dentist for inclusion in the Kansas City Life Dental Alliance Provider Network. I understand that my name may be used when contacting my dentist to inform him/her of my desire for him/her to join the network.

DATE: _____

Employer: _____

Kansas City Life Group Number: _____

Employee: _____

Address/City/State/Zip: _____

Phone: _____

E-mail: _____

DENTIST'S INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Specialty: _____

Please submit completed form to:

Kansas City Life Group Benefits
PO BOX 219425
Kansas City, MO 64121-9425
Fax: 816-931-4006
CFI@kclife.com