Allied

Please complete and return via fax or e-mail:

E-Mail: BPODental.Eligibility@alliedbenefit.com
Fax: (312) 602-6272

AMERICAN NATIONAL
American National Life Insurance Company of Texas

DENTAL EMPLOYEE ENROLLMENT APPLICATION

ENROLLMENT INFORMATION	□ New Employee/Dependent □ Name Change □ Address Change	
EMPLOYER INFORMATION		
Employer Name:		Employer Group Number:
EMPLOYEE INFORMATION		
Last Name:	First Name:	Middle Initial:
Phone Number:	Email:	Social Security Number:
Gender: □ Male □ Female	Marital Status: □ Single □ Married	Date of Birth:
Physical Street Address:	City:	State: / Zip:
Occupation/Title:	Employment Status:□ Active □Inactive	Date of Full-Time Enrollment:

COVERAGE ELECTION

□ Employee Only □ Employee and Spouse □ Employee and Child(ren) □ Employee and Family

DEPENDENT INFORMATION

Spouse/Dependent Name (First, Last, MI)	Gender	Date of Birth	Social Security Number

REFUSAL/WAIVER OF COVERAGE

I decline coverage for: □ Myself □ Spouse □ Child(ren)	Reason for Refusal/Waiver: □ Cost □ Other coverage

ACKNOWLEGDEMENT AND AUTHORIZATION

I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group dental plan offered by my Employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage, treatments, and services I may receive may be distributed and disclosed to my employer. I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete. WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

SIGNATURE OF EMPLOYEE:	**DATE:**