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 |
|---|---|---|---|
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| **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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties.

| **SIGNATURE OF EMPLOYEE:** | **DATE:** |
|---|---|
| | |