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. To the best of my knowledge and belief, I declare all answers to be 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:** |
|---|---|