

Please complete and return via fax or e-mail:

E-Mail: <u>BPO.Dental.Eligibility@alliedbenefit.com</u> Fax: (312) 602-6272



American National Life Insurance Company of Texas

## DENTAL EMPLOYEE ENROLLMENT APPLICATION

EMPLOYER INFORMATION       Employer Group Number:         EMPLOYEE INFORMATION       Employer Group Number:         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 Innactive       Date of Full-Time Enrollment         Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number:         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Gecline coverage for:       Myself       Spouse       Child(ren)       Reason for Refusal/Waiver:       Cost       Other coverage         AckNowLEGDEMENT AND AUTHONIZATION       Interverse as outline above under the American National Life Insurance Company of Texas group dental plan offered by my employer.       I authorize my employeer of equals and proves or change this authorization by written notice.       I other coverage for engligble dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisio	ENROLLMENT INFORMATION   New Employee/Dependent  Name Change  Address Change							
EMPLOYEE INFORMATION         Last Name:       First Name:         Middle Initial:         Phone Number:       Email:         Gender:       Male         Physical Street Address:       City:         State:       Zip:         Occupation/Title:       Employment Status:       Active Date of Full-Time Enrollment         Derender:       Employee and Spouse       Employee and Child(ren)       Date of Full-Time Enrollment         Occupation/Title:       Employee and Spouse       Employee and Child(ren)       Employee and Family         Derender:       Imployee and Spouse       Employee and Child(ren)       Employee and Family         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         REFUSAL/WAIVER OF COVERAGE       Imployee Child(ren)       Reason for Refusal/Waiver:       Cost       Other coverage         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 enrolt								
Last Name:       First Name:       Middle Initial:         Phone Number:       Email:       Social Security Number:         Gender:       Image: Im	Employer Name:					Employer Group Number:		
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 and Spouse       Employee and Child(ren)       Employee and Family         DEFENDENT INFORMATION       Social Security Number       Social Security Number         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Idecline coverage for:       Myself       Spouse       Child(ren)       Employee control       Other coverage         ACKNOWLEGOEMENT AND AUTHORIZATION       Idecline coverage for:       Myself       Spouse       Child(ren)       Reason for Refusal/Waiver:       Cost       Other coverage         ACKNOWLEGOEMENT AND AUTHORIZATION       Idecline dayustments, 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 enrol at a later date, coverage will be deferred in accordance with the plan provisions. I understand and disclosed to my employer. I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete. <td colspan="8">EMPLOYEE INFORMATION</td>	EMPLOYEE INFORMATION							
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       Social Security Number       Social Security Number         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         I decline coverage for:       Myself       Spouse       Child(ren)       Employee on or provemant of the social Security Number         I decline coverage for:       Myself       Spouse       Child(ren)       Reason for Refusal/Waiver:       Cost       Other coverage         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 se	Last Name:	Fi	rst Name:			Middle Initial:		
Physical Street Address:       City:       State:       Zip:         Occupation/Title:       Employment Status:::       Active □lnactive       Date of Full-Time Enrollment         COVERAGE ELECTION       □       Employee and Spouse       □ Employee and Family         DEPENDENT INFORMATION       Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         I decline coverage for:       Inyself       Spouse       Child(ren)       Imployee only       Imployee         I decline coverage for:       Inyself       Spouse       Child(ren)       Reason for Refusal/Waiver::       Cost       Other coverage         ACKNOWLEGDEMENT AND AUTHORIZATION       Imployee:       I authorize 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 understand and acknowledge that information.       I declare all answers true and complete. <td>Phone Number:</td> <td>Eı</td> <td>mail:</td> <td></td> <td colspan="2">Social Security Number:</td>	Phone Number:	Eı	mail:		Social Security Number:			
Occupation/Title:       Employment Status::: Active Inactive       Date of Full-Time Enrollment         COVERAGE ELECTION       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         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse (Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse (Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse (Dependent Name (First, Last, MI)       Gender       Date of Refusal/Waiver:: Cost       Other coverage         Image: Spouse (Dependent Name (First, Last, MI)       Gender       Reason for Refusal/Waiver:: Cost       Other coverage         Image: Spouse (Dependent Name (First, Last, MI)       Gender       Reason for Refusal/Waiver:: Cost       Other coverage         Image: Spouse (Dependent Name (First, Last, MI)       Gender       Reason for Refusal/Waiver:: Cost       Other coverage         Image: Spouse (Dependent And Withiter)       Reason for Refusal/Waiver:: Cost       Other coverage       Other coverage         Image: Spouse (Dependent And With Intent to injure, defraud, or deceve or change this authoriza	Gender: 🗆 Male 🗆 Female	N	larital Statu	us: 🗆 Single 🗆 Marr	Date of Birth:			
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         Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse/Dependent Name (First, Last, MI)       Gender       Date of Birth       Social Security Number         Image: Spouse (Company Company)       Gender       Date of Birth       Social Security Number         Image: Spouse (Company Company)       Gender       Date of Birth       Social Security Number         Image: Spouse (Company Company)       Gender       Date of Birth       Social Security Number         Image: Spouse (Company Company)       Gender       Gender       Date of Birth       Social Security Number         Image: Spouse (Company Company Company)       Gender	Physical Street Address:	Ci	ity:		State:	Zip:		
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