

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								
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