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.

SIGNATURE OF EMPLOYEE:	**DATE:**