American National
Life Insurance Company of Texas

DENTAL EMPLOYER MASTER APPLICATION

REQUESTED EFFECTIVE DATE OF COVERAGE:	_____ 1st, 2017.		
GROUP INFORMATION			
Legal Name of Employer Applicant (Policyholder):			
Phone Number:	Email:	Federal Tax ID:	
Nature of Business:		SIC Code:	
Mailing Address:	City:	State:	Zip:
Street Address (If different from above):	City:	State:	Zip:
Name of Subsidiaries, Divisions or Affiliates to be Covered:			
Name and Title of Plan Administrator/Human Resources Contact:			
ELIGIBILITY			
Number of Employees on Payroll:	Number of Full-Time Employees:		
Description of Classes Not Eligible for Coverage:			
New Hire Waiting Period – First of the Month following continuous full-time employment:	□ Date of Hire □ One Full Calendar Month □ Two Full Calendar Months		

EMPLOYER CONTRIBUTION

□ Employer Sponsored Coverage – Requires minimum of 50% contribution toward the cost of Employee.
□ Voluntary Coverage – Employer is not required to contribute to the cost of Coverage.

Employer Contribution for Employees: _____%

Employer Contribution for Dependents: _____%

PRIOR COVERAGE INFORMATION

Will this dental insurance replace previous group dental insurance? □ Yes □ No

If Yes, please indicate the Prior Carrier Name: _____

Original Effective Date: _____ Termination Date: _____

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USBenefits CHOICE Dental – BENEFIT OPTIONS						
Plan Name	**Deductible**	**Calendar Year Maximum**	**Co-Insurance**	**Oral Surgery**	**Endodontics**	**Periodontics**
Superior	□$0 □$25 □$50	□$3,000 □$2,500 □$2,000 □$1,500	In: 100/90/60 Out: 100/90/60	□ Basic □ Major	□ Basic □ Major	□ Basic □ Major
Balanced	□$0 □$25 □$50	□$2,500 □$2,000 □$1,500 □$1,000	In: 100/80/50 Out: 100/80/50	□ Basic □ Major	□ Basic □ Major	□ Basic □ Major
Essential	□$0 □$25 □$50	□$1,500 □$1,000 □$500	In: 100/80/0 Out: 100/80/0	□ Basic □ Major	□ Basic □ Major	□ Basic □ Major
USBenefits CHOICE PPO Dental – BENEFIT OPTIONS						
Plan Name	**Deductible**	**Calendar Year Maximum**	**Co-Insurance**	**Oral Surgery**	**Endodontics**	**Periodontics**
Superior PPO	□$0 □$25 □$50	□$3,000 □$2,500 □$2,000 □$1,500	In: 100/90/60 Out: 100/80/50	□ Basic □ Major	□ Basic □ Major	□ Basic □ Major
Balanced PPO	□$0 □$25 □$50	□$2,500 □$2,000 □$1,500 □$1,000	In: 100/80/50 Out: 80/80/50	□ Basic □ Major	□ Basic □ Major	□ Basic □ Major
Essential PPO	□$0 □$25 □$50	□$1,500 □$1,000 □$500	In: 100/80/0 Out: 80/50/0	□ Basic □ Major	□ Basic □ Major	□ Basic □ Major

ORTHODONTIA	**REIMBURSEMENT**
Child Orthodontia: □Yes □No Lifetime Maximum: □$2,000 □$1,500	□ UCR (Usual, Customary and Reasonable) □ MAC (Maximum Allowable Charge)
PLAN OPTIONS	
Based on Policyholder contribution and total participation, this dental plan is: □ Employer Sponsored □ Voluntary	Is more than one dental plan offered? □Yes □No If multiple plans are offered, please indicate the following: □Dual Option □Triple Option

AGREEMENT AND SIGNATURES

Warning: Any person who knowingly and with intent to defraud and 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. It is understood and agreed as follows:

1. No coverage is effective until the approved by American National Life Insurance Company of Texas.
2. Insurance will be effective: the effective date approved by the Company; and the date the first premium is paid in full.
3. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. The employer Applicant agrees to make the appropriate premium deductions from each Insured's payroll check, if applicable, and remit payment to Allied Benefit Systems, Inc. within 30 days of the deduction.

Signature of Writing Agent:		Agent Code:
Agent/Agency Name:	Business Address:	Phone Number:
Print Employer Applicant/Policyholder Name:		