



**American National Life Insurance Company of Texas**  
**Send All Correspondence to:**  
**P.O. Box 7809**  
**Visalia, CA 93291**



**Administrator**

**Employer Section**

Employer Name		Group Number
Full Time Hire Date	Phone Number	

**Employee Section**

Last Name		First Name	MI	Date of Birth	
Street Address/Apt/No			City	State	Zip
Male ( )	Female ( )	Married ( )	Single ( )	Social Security Number	
E-mail Address		Telephone Number(s)			

**Fill in the following information for each person to be covered starting with yourself. Use separate page if necessary.**

Last Name Only If Different From Above	First Name	MI	Relationship	Sex M/F	Age	Date of Birth		
						Mo	Day	Year
			Self					
			Spouse					
			Dependent					
			Dependent					
			Dependent					
			Dependent					

**Coverage Section**

I am applying for coverage on: <input type="checkbox"/> Single <input type="checkbox"/> Single + spouse <input type="checkbox"/> Single + children <input type="checkbox"/> Family I decline my option for dental coverage: <input type="checkbox"/> Decline		I select: Freedom Plan: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 PPO Network: _____ See <a href="http://www.benelect.com">www.benelect.com</a> for network selections. If no network is selected, one will be assigned.	
Does spouse have a dental plan <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list carrier		

If yes, please list any dependents covered under another dental insurance plan:

Name

Carrier

_____	_____
_____	_____
_____	_____
_____	_____

Are any of the above listed dependent(s) age 19 (22 in ND) or older, students?\* Yes \_\_\_ No\_\_\_

If yes, please indicate the name, school attending and status:

Name

School

Status

\_\_\_Part-Time \_\_\_Full-Time

_____	_____	___Part-Time ___Full-Time
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_____	_____	___Part-Time ___Full-Time
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\*Dependent eligibility will vary by state. On average, dependents ages 19-24 are eligible based on full time student status with proof of status.

### Employee Acknowledgement 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 to the best of my knowledge and belief.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Agent's signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name