



American National Life Insurance Company of Texas
 One Moody Plaza, Galveston, Texas 77550

Group Information

Legal Name of Employer			
Street Address	City	State	Zip
Federal Tax ID	Nature of Business	SIC Code	
Number of Eligible Employees			
Contact Name	Contact Title	Telephone #	
Fax #	E-mail Address		

Product Information

Proposed Effective Date of Coverage*	
Employee Benefit Waiting Period: <u>1st</u> of the Month Current Employees: _____ Month(s) New Employees: _____ Month(s)	Voluntary () Employer Paid () Contribution: Employer Participation if Employer Paid: Based on Freedom Plan _____ Employee*: _____ % or \$ _____ Dependent: _____ % or \$ _____ <small>*Minimum contribution 50% of the lowest cost plan for employee. No minimum for dependent.</small>
<u>Freedom Dental Plan to offer:</u> <input type="checkbox"/> Freedom One <input type="checkbox"/> Freedom Six <input type="checkbox"/> Freedom Two <input type="checkbox"/> Freedom Seven <input type="checkbox"/> Freedom Three <input type="checkbox"/> Freedom Eight <input type="checkbox"/> Freedom Four <input type="checkbox"/> Freedom Nine <input type="checkbox"/> Freedom Five <input type="checkbox"/> Freedom Ten <input type="checkbox"/> All Plans Employer can offer any or all of the plans to its employees.	<u>PPO Selection:</u> Multiple PPO Networks are available and may be selected at the employee level or the employer may select the network. <input type="checkbox"/> Employee may select <input type="checkbox"/> Employer selected: _____ <u>Out of Network:</u> <input type="checkbox"/> In-Network PPO Allowance Fee <input type="checkbox"/> 80 th Percentile UCR* <small>*80th percentile UCR option rates are 10% higher than the rates for benefits paid at the in-network PPO allowance fee.</small>

*Actual Effective Date will be issued by the Company and shown in the Policy Schedule of Benefits.

Prior Carrier Information

If the coverage within this application replaces, or is in addition to, any similar group insurance currently or previously in-force, please indicate below:	
Carrier Name	Type of coverage
Effective date of coverage	Term date (if in-force, please indicate)

For prior coverage credit to be considered, this application must be accompanied by a current month's billing statement from the current carrier (depicting insured individual(s) and dependents), a copy of an in-force certificate and benefit schedule.

Please tell us about your group's eligibility...

1. Total number of employees (including owners/officers)	_____
2. Number of eligible full time employees (working a minimum of 30 hours per week)	_____
3. Are part time employees to be covered? 20 – 29 hours weekly	() Yes () No
4. Number of eligible part time employees	_____
5. Is this group a class carve-out?	() Yes () No
If yes, state class of employees to be covered: _____	
6. Do you wish to offer coverage for opposite sex domestic partners* under the age of 62?	() Yes () No
7. Is your group currently subject to COBRA? (Employed 20 or more total employees on at least 50% of the working days in the previous calendar year; and not subject to Cal-COBRA)	() Yes () No
8. Is your group subject to the Family Medical Leave Act of 1993?	() Yes () No

**We comply with State law requiring us to cover spouses and qualified domestic partners including dependents to the same extent and subject to the same terms and conditions as a spouse. To be an eligible domestic partner one must be a domestic partner registered under a valid Declaration of Domestic Partnership filed with the California Secretary of State, or an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnership.*

Acknowledgement

1. No coverage is effective until approved by [Benelect] on the date shown in the Policy.
2. Insurance will be effective on the latest of the following dates: a) date requested by the employer applicant, b) the date the application is signed, c) the date the first premium is paid in full.
3. No agent has the right 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 notify [Benelect] of changes to the above numbers representing a change of five percent or more and agrees to provide [Benelect], upon request, payroll records verifying number of employees.
5. The employer applicant acknowledges that if the contributory status or participation percentage change that [Benelect] reserves the right to adjust the premiums and rates accordingly.
6. The statements in this enrollment application are deemed to be representations and not warranties.
7. A \$25 monthly billing fee will be added to the employer's invoice.

_____	_____	_____
Employer's Representative Signature	Date	Print Full Name
_____	_____	_____
Agent's Signature	Date	Print Full Name

Agent's Address		