AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

ONE MOODY PLAZA, GALVESTON, TEXAS

DENTAL APPLICATION

WARNING: Any person who knowingly and with intent to defraud an 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.

☒ Single Option ☐ Dual Option Plan Name(s) _____

GROUP INFORMATION			
Legal Name of Employer Applicant (Policyholder):			
Applicant's Phone Number:	Federal Tax ID No.		
Nature of Business:	SIC Code:		
Mailing Address:	City:	State:	Zip Code:
Street Address (if different from above):	City:	State:	Zip Code:
Name of Subsidiaries, Divisions or Affiliates to be Covered:			
Name and Title of Employer Plan Administrator/Human Resources Contact:	Phone Number: ( )	Fax Number: ( )	
Proposed Effective Date of Insurance:	Email Address:		
Advance payment of $_____ is submitted herewith to be applied by the Company to premiums for insurance when and if issued.			

ELIGIBILITY

Eligible Classes:
_____ Minimum Hours Per Week _____Weeks Per Year
☐ All Full Time Employees
☐ Other_____ _____ Number Eligible

Employee Benefit Waiting Period:
☐ 0 ☐ 30 ☐ 60 ☐ 90 days ☐ _____

Current Employees: _____ Day Waiting Period
New Employees: _____ Day Waiting Period

Any excluded classes of employees? ☐ Yes ☐ No If yes, give details on reverse side.

Effective Date of Coverage / Termination Date of Coverage

Option 1 ☐ Effective immediately/terminated on the last day for which premium has been paid.

Option 2 ☒ Effective the first day of the month coincident with or next following the date the Employee Benefit Waiting Period is completed and application is approved/terminated on the last day for which premium has been paid.

Note: Option 2 always applies to voluntary coverage.

Late Enrollee restrictions apply: ☒ Yes ☐ No

Will this plan be part of a Sec. 125 Salary Reduction Plan: ☐ Yes ☐ No
If yes, attach a copy of the Sec. 125 document page.

PRIOR CARRIER INFORMATION

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

N/A	N/A	N/A
Carrier Name	Type of Coverage	Termination Date

For Credit for Prior Coverage to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each insured individual and dependents, if insured.

SEE OTHER SIDE

PREMIUM / MONTHLY COST

Billing Class	# Covered		Cost	Total
Employee		X	$	$
Two Party		X	$	$
Family		X	$	$
		X	$	$
		X	$	$
			Monthly Billing Fee:	$
			Total Monthly Cost:	$

Premium Information: ☐ 100% Employer paid OR

Employee Coverage: Employer Contribution: _____ Employee Contribution: _____

Dependent Coverage: Employer Contribution: _____ Employee Contribution: _____

SCHEDULE OF BENEFITS

	Benefit Waiting Period	Deductible Amount per Person	Coinsurance Percentage
Diagnostic Care			
Basic Care			
Major Care			
Orthodontics			

Orthodontics ☒ Yes ☐ No If Yes, Benefit Year Limit $ _____ Lifetime Maximum $ _____

Lifetime Deductible Amount ☐ Yes ☒ No If Yes, Amount per person $ _____

Co-payment ☐ Yes ☒ No If Yes, Amount per visit $ _____

NOTE: If a PPO Option is selected, benefits payable under the Policy may decrease each time an Insured uses a Non-Preferred Provider. Please refer to the Policy for more information.

AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

1. No coverage is effective until approved by American National Life Insurance Company of Texas, Galveston,Texas.
2. Insurance will be effective with regard to those individuals listed in the Eligibility Section on either of the following dates: (a) the effective date approved by the Company; (b) the date this application is signed; or (c) 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 to American National Life Insurance Company of Texas its administrator within 30 days of the deduction.

Dated at: _____ this _____ day of _____, 20 __

Signature of Writing Agent	Agent Code	Applicant's Signature
Signature of Other Agent(s)	Agent Code	Type or Print Applicant's Name
Agency Name		Agent's Phone Number
Agent's Business Address	City	State / Zip

SPECIAL REQUESTS

Send Administration Kit, Certificates, and ID Cards to: ☐ Broker ☒ Policyholder