AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

ONE MOODY PLAZA, GALVESTON, TEXAS

DENTAL ENROLLMENT FORM

Administered By: Dentist Direct, LLC
75 South 500 West, Bountiful, UT 84010

EMPLOYER INFORMATION		
EMPLOYER NAME	LOCATION	GROUP NO.

EMPLOYEE			
LAST NAME	FIRST NAME		M.I.
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )		BIRTH DATE / /

SEX	EMPLOYMENT DATE	MARITAL STATUS	OCCUPATION/TITLE	EMPLOYMENT STATUS
MALE ☐ FEMALE ☐	MM / DD / YY	SINGLE ☐ MARRIED ☐		ACTIVE ☐ INACTIVE ☐

COVERAGE – Check Those That Apply

☐ EMPLOYEE ☐ SPOUSE ☐ CHILDREN REQUESTED EFFECTIVE DATE:____________

DEPENDENT INFORMATION			
SPOUSE NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No
CHILD NAME	SEX ☐ MALE ☐ FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) ☐ Yes ☐ No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE?______________________
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:
____

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILDREN
REASON FOR REFUSAL:____

ACKNOWLEDGMENT 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.

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.

DATE	CITY AND STATE
SIGNATURE OF EMPLOYEE	