

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.
Note: California law prohibits an HIV test from being required or used by a health insurance company as a condition of obtaining coverage.

(Matrix) (PPO Option) (Flexident) – Plan Name _____

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:

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Proposed Effective Date of Insurance:

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 (Note: Late Enrollee restrictions do not apply to voluntary coverage.)

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.

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
_____	_____	X	\$ _____	\$ _____
_____	_____	X	\$ _____	\$ _____
_____	_____	X	\$ _____	\$ _____
_____	_____	X	\$ _____	\$ _____
_____	_____	X	\$ _____	\$ _____
			Monthly Billing Fee:	\$ _____
			Total Monthly Cost:	\$ _____

[Premium Information: 100% Employer paid OR

Employee Coverage: _____ Employer Coverage: _____ Employee Contribution: _____ Area Factor Quoted: _____
 Dependent Coverage: _____ Employer Contribution: _____ Employee Contribution: _____ Zip Code Quoted:] _____

[SCHEDULE OF BENEFITS			
Benefit	Waiting Period	Deductible Amount per Person	Coinsurance Percentage
Preventive Care	_____	_____	_____
Diagnostic Care	_____	_____	_____
Basic Care	_____	_____	_____
Major Care	_____	_____	_____
Prosthodontics	_____	_____	_____
Orthodontics	_____	_____	_____
Prosthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Calendar Year Limit \$ _____	Lifetime Maximum \$ _____
Orthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Calendar Year Limit \$ _____	Lifetime Maximum \$ _____

NOTE: If the PPO Option is checked, benefits payable under the Policy will 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:
- No coverage is effective until approved by American National Life Insurance Company of Texas, Galveston, Texas.
 - 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.
 - No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
 - 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 _____, 200__

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