QCD of America
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

NLLEO ENROLLMENT FORM- GROUP DALLP

qcd DENTAL BENEFITS

DENTAL PLAN:
RED ____
RED PLUS ____
WHITE ____
BLUE ____
NONE ___

DENTAL COVERAGE:
EMPLOYEE ONLY ___
EMPLOYEE + ONE ___
EMPLOYEE + FAMILY ___

VISION PLAN:
FASHION ___
DESIGNER ___
DESIGNER GOLD ___
NONE ___

VISION COVERAGE:
EMPLOYEE ONLY ___
EMPLOYEE + ONE ___
EMPLOYEE + FAMILY ___

Last Name	First Name	MI	Date of Birth
Address	City	State	Zip
Social Security Number	Telephone		
Sex ____Male ____Female	Effective Date	Hire Date	

DEPENDENT INFORMATION

	Last Name	First Name	MI	Date of Birth	Gender	Relationship
						SPOUSE

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

I DECLINE COVERAGE FOR: ☐ MYSELF ☐ SPOUSE ☐ CHILDREN

REASON FOR REFUSAL: _____

I hereby request coverage as outlined above under the American National Life Company of Texas group dental and/or vision plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any requited 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 dependents 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 Applicant Signature