QCD of America
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

NLLEO ENROLLMENT FORM- GROUP DALLP

qcd DENTAL BENEFITS

DENTAL PLAN:	DENTAL COVERAGE:	VISION PLAN:	VISION COVERAGE:
RED DISCOUNT	EMPLOYEE ONLY	QCD RED DISCOUNT VISION	EMPLOYEE ONLY
RED PLUS	EMPLOYEE PLUS	FASHION VISION	EMPLOYEE PLUS
WHITE	EMPLOYEE PLUS	DESIGNER VISION	EMPLOYEE PLUS
BLUE	NONE	DEISGNER GOLD VISION	NONE
NONE		NONE	

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
TYPE NAME AND LAST 4 SS# TO CONFIRM ENROLLMENT

SUBMIT ENROLLMENT