

SERFF Tracking Number: ANTX-125712164 State: Arkansas
Filing Company: American National Life Insurance Company of Texas State Tracking Number: 39586
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: kelsey dental enrollment form
Project Name/Number: kelsey dental enrollment form/kelsey dental enrollment form

Filing at a Glance

Company: American National Life Insurance Company of Texas

Product Name: kelsey dental enrollment form SERFF Tr Num: ANTX-125712164 State: ArkansasLH
TOI: H10G Group Health - Dental SERFF Status: Closed State Tr Num: 39586
Sub-TOI: H10G.000 Health - Dental Co Tr Num: State Status: Approved-Closed
Filing Type: Form Co Status: Submitted Reviewer(s): Rosalind Minor
Author: Sherry Wiegman Disposition Date: 07/11/2008
Date Submitted: 07/10/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: kelsey dental enrollment form Status of Filing in Domicile: Authorized
Project Number: kelsey dental enrollment form Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Association
Filing Status Changed: 07/11/2008 Deemer Date:
State Status Changed: 07/11/2008
Corresponding Filing Tracking Number:

Filing Description:

Attached for your review and consideration is a new internet dental enrollment form. This is a new form submission that has not been previously reviewed or rejected.

This enrollment form will be located on a dental quote website and is used in conjunction with our previously approved group association dental product (form dent06-cer-ar approved February 13, 2007). Although there are 4 sites being submitted, this constitutes one enrollment form. Each page reflects a different segment of the enrollment form.

SERFF Tracking Number: ANTX-125712164 State: Arkansas
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 Product Name: kelsey dental enrollment form
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Variable information is indicated in brackets. The variable language and amounts are notated on the form and consist only of the applicant's information and specific plan design and selection.

We trust this information is complete and look forward to receiving your favorable reply. Please contact me at the address or numbers listed if you feel additional information is needed or if I can be of assistance.

Company and Contact

Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst sherry.wiegman@anico.com
 One Moody Plaza 17th Floor (409) 621-7779 [Phone]
 Galveston, TX 77550 (409) 766-2950[FAX]

Filing Company Information

American National Life Insurance Company of Texas CoCode: 71773 State of Domicile: Texas
 One Moody Plaza 17th Floor Group Code: -99 Company Type: Health Insurance
 Galveston, TX 77550 Group Name: State ID Number:
 (409) 621-7779 ext. [Phone] FEIN Number: 75-1016594

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Life Insurance Company of Texas	\$50.00	07/10/2008	21350520

SERFF Tracking Number: ANTX-125712164 State: Arkansas
Filing Company: American National Life Insurance Company of Texas State Tracking Number: 39586
Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: kelsey dental enrollment form
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/11/2008	07/11/2008

SERFF Tracking Number: ANTX-125712164 *State:* Arkansas
Filing Company: American National Life Insurance Company of *State Tracking Number:* 39586
Texas
Company Tracking Number:
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: kelsey dental enrollment form
Project Name/Number: kelsey dental enrollment form/kelsey dental enrollment form

Disposition

Disposition Date: 07/11/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ANTX-125712164 State: Arkansas

Filing Company: American National Life Insurance Company of Texas State Tracking Number: 39586

Company Tracking Number:

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: kelsey dental enrollment form

Project Name/Number: kelsey dental enrollment form/kelsey dental enrollment form

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	internet enrollment form	Approved-Closed	Yes
Form	internet enrollment form	Approved-Closed	Yes
Form	internet enrollment form	Approved-Closed	Yes
Form	internet enrollment form	Approved-Closed	Yes

SERFF Tracking Number: ANTX-125712164 State: Arkansas
 Filing Company: American National Life Insurance Company of Texas State Tracking Number: 39586
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: kelsey dental enrollment form
 Project Name/Number: kelsey dental enrollment form/kelsey dental enrollment form

Form Schedule

Lead Form Number: <https://www.dentalinsurance.com/di/web/provider/application.aspx>

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	https://www.dentalinsurance.com/di/web/provider/application.aspx	Application/Enrollment Form	internet enrollment form	Initial		45	AR Kelsey Enr Form 1.pdf
Approved-Closed	https://www.dentalinsurance.com/di/web/provider/application2.aspx	Application/Enrollment Form	internet enrollment form	Initial		45	AR Kelsey Enr Form 2.pdf
Approved-Closed	https://www.dentalinsurance.com/di/web/provider/application3.aspx	Application/Enrollment Form	internet enrollment form	Initial		45	AR Kelsey Enr Form 3.pdf
Approved-Closed	https://www.dentalinsurance.com/di/web/provider/thanks.aspx	Application/Enrollment Form	internet enrollment form	Initial		45	AR Kelsey Enr Form 4.pdf



plan 1

HIGHLIGHTS | FEATURES | PLAN INFO | PLAN COST | FAQ'S | DENTISTS | **APPLICATION**

>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

enrollment application for plan 1

FOLLOW THESE SIMPLE DIRECTIONS

1. Complete the information requested about you and your dependents.
2. Include your bank account information for payment.
3. Apply on-line by clicking the SUBMIT button.
4. Please print out a copy of your application for your records.
You will be sent an email confirming receipt of your application.

questions

- Q How long does it take to process my application?
- Q When will I receive my enrollment package and what will it include?
- Q Do the applicant name and the billing name need to be the same?
- Q What if I need to change my membership from Individual to Family Coverage?

ELIGIBILITY

Eligible persons are members of the National Consumer's Advantage Association and their eligible dependents. Age limits for eligible dependent children may vary by state.

EFFECTIVE DATE

If your application and payment information is submitted by the 20th of the month, your coverage will be effective on the 1st of the following month. If it is submitted after the 20th of the month, your coverage will be effective on the 1st of the second following month. The effective date will be shown on your I.D. card issued by the Company

Applicant Information

first name middle initial last name

social security # - -

street address 1

street address 2

city state zip code

daytime phone # - - cell phone # - -

fax # - - email address

will you or any other dependent(s) have other dental insurance coverage? NO YES

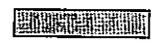
if yes, please list the insurance company name and phone number.

CENSUS

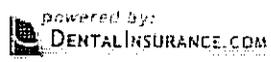
birthday

first name, last name	gender	mm/dd/yyyy	relationship	student
<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	applicant	>>
<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>

Need room for more dependents? [click here >>](#)



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plan 1

HIGHLIGHTS FEATURES PLAN INFO PLAN COST FAQ'S DENTISTS **APPLICATION**

>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

Plan Cost and Payment Options

Plan Cost

	MONTHLY	QUARTERLY
INITIAL PLAN COST:	\$18.64	\$55.92
PLUS PROCESSING FEE:*	\$25.00	\$25.00
PLUS BILLING FEE:	\$3.00	\$3.00
PLUS NCAA FEE:	\$1.00	\$3.00
TOTAL AMOUNT DUE:	\$47.64	\$86.92

Payment Options

INITIAL PAYMENT OPTIONS: ACH ACH

ONGOING PAYMENT OPTIONS: ACH ACH

Effective Date

EFFECTIVE DATE: 5/1/2008

* Processing fee is one time non-refundable.



THE COMPANY ACCEPTS THE FOLLOWING PAYMENT TYPES:

INITIAL PAYMENT

Below are the choices for your initial payment.

Monthly E-Check

Quarterly E-Check

ONGOING PAYMENT(S)

Below are the corresponding choices for ongoing payment(s).

Monthly E-Check

Quarterly E-Check

YOUR PAYMENT(S) WILL BE PROCESSED AS FOLLOWS

INITIAL PAYMENT

- Monthly E-Check**

If application is received by the 20th of the month, e-check is drafted on the 25th day of that month.

If application is received after the 20th of the month, e-check is drafted on the 25th day of the following month.
- Quarterly E-Check**

If application is received by the 20th of the month, e-check is drafted on the 25th day of that month.

If application is received after the 20th of the month, e-check is

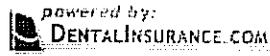
drafted on the 25th day of the following month.

ONGOING PAYMENT

Monthly E-Check Processed on the 25th day of each month.

Quarterly E-Check Processed on the 25th day of the first month of each quarter.

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plan 1

HIGHLIGHTS | FEATURES | PLAN INFO | PLAN COST | FAQ'S | DENTISTS | **INITIAL PAYMENT**

>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

Initial Payment

MONTHLY ACH

INITIAL ONE MONTH'S PAYMENT:	\$18.64
PLUS PROCESSING FEE:	\$25.00
AND BILLING FEE:	\$3.00
AND NCAA FEE:	\$1.00
TOTAL INITAL PAYMENT:	\$47.64

Ongoing Payment

MONTHLY ACH

ONGOING ONE MONTH'S PAYMENT:	\$18.64
AND BILLING FEE:	\$3.00
AND NCAA FEE:	\$1.00
TOTAL ONGOING PAYMENT:	\$22.64

Payment Information for Bank Account Draft (ACH)

financial institution <input style="width: 100%;" type="text"/>	account type: <input type="radio"/> checking <input type="radio"/> savings
branch name <input style="width: 100%;" type="text"/>	branch phone number <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>
personal routing number <input style="width: 100%;" type="text"/> <small>(First 9 digits found on bottom left corner of deposit slip)</small>	account number <input style="width: 100%;" type="text"/> <small>(4-14 digits, including all zeros, found next to routing number)</small>

ROUTING AND ACCOUNT NUMBERS LOCATIONS :

Check or Deposit Slip

<small>John and Jane Doe 1434 Dental Road Crown Point, IN 46035</small>	9999 Date _____
Pay to the Order of _____	\$ <input style="width: 50px;" type="text"/>
<small>First National Bank of Des Moines 1231 First Web Road Des Moines, IA 50315</small>	
For _____	Dollars
1:1234567891:123 @123456789 9999	
<small>Transit Routing Number Account Number Check Number</small>	

Declaration and Agreements

National Consumer Advantage Association enrollment

I understand that in order to purchase this Dental Insurance plan, I must first become a member of the National Consumer's Advantage Association (NCAA). I understand that NCAA members are entitled to receive Car Rental Discount Coupons, Vision Care Discounts, Travel Club Benefits, and various other consumer and discount materials. Under Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to NCAA, I appoint its President as my proxy to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend. I hereby apply for membership in the National Consumer's Advantage Association. I understand that membership dues are \$1.00 monthly and are to be drafted from my account along with the premium for the dental insurance plan.

I understand that an electronic signature on this Association Enrollment is legal and enforceable. I also understand that any electronic signature to this form operates as my original signature.

* applicant full name

test t test

* applicant full name (re-enter for verification)

Automatic Payment Authorization

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of American National Life Insurance Company of Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of coverage.

Important Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

Acknowledgement and Authorization

I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group dental plan offered by the National Consumer's Advantage Association. I, the undersigned applicant, have personally completed the enrollment application and represent that all answers are true and complete to the best of my knowledge and belief. The statements in this enrollment application are deemed to be representations and not warranties. I understand and agree that the insurance will not take effect unless the enrollment application has been accepted and approved by American National Life Insurance Company of Texas and until the effective date as stated in the Identification card, if issued.

I understand that an electronic signature on this enrollment application is legal and enforceable. I also understand that any electronic signature to this form operates as my original signature.

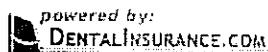
* applicant full name

test t test

* applicant full name (re-enter for verification)



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thank you

your application has been submitted...

* Note: Once payment is processed and eligibility is confirmed you will be automatically approved for this plan

Please PRINT for your records...

Thank You test test.
Your application for American National Life Insurance Company of Texas Plan 1 has been submitted.

* Please allow 10-14 business days to receive your ID card and package in the mail.

APPLICANT INFORMATION

Applicant Name: test t test
E-mail Address: test@test.com
Address:
111
111, AR 71601
Day Phone: 111-111-1111
Cell Phone: --
Fax: --

CENSUS INFORMATION

test test
applicant

PLAN SUMMARY

Confirmation Number: 77251
Provider: American National Life Insurance Company of Texas
Plan Name: Plan 1
Plan Type: Indemnity
Number of Members: 1

Total Initial Payment: \$47.64 ACH
Total Ongoing Payment: \$22.64 MONTHLY ACH

Requested Effective Date:
05/01/2008

CONTACT INFORMATION

If you have any questions, please see the Frequently Asked Questions.

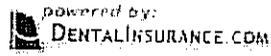
For further questions,
please call American National Life Insurance Company of Texas
Billing at 800-366-5656 ;
or Claims/Eligibility at 800-935-2009 .

Thank you,

DentalInsurance.com
800-296-3800

customersupport@DentalInsurance.com

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Company Tracking Number:
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: kelsey dental enrollment form
Project Name/Number: kelsey dental enrollment form/kelsey dental enrollment form

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 07/11/2008
Comments:
Attachment:
AR Kelsey Cert of Compl.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 07/11/2008
Comments:
Attachment:
AR Kelsey Enrollment Form.pdf



AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

STATE OF ARKANSAS

COMPLIANCE CERTIFICATION

Regarding:

<https://www.dentalinsurance.com/di/web/provider/application.aspx>
<https://www.dentalinsurance.com/di/web/provider/application2.aspx>
<https://www.dentalinsurance.com/di/web/provider/application3.aspx>
<https://www.dentalinsurance.com/di/web/provider/thanks.aspx>

I have reviewed or supervised the review of the forms contained in this filing and hereby certify that they are in compliance with the applicable statutes, regulations, and bulletins of the State of Arkansas. I further certify that they will be revised and/or discontinued in the event of future changes in the statutes, regulations, or bulletins which would prohibit the use of such forms.

James P. Stelling
Vice President, Health Compliance

06/08/08

Date of Signature



plan 1

HIGHLIGHTS | FEATURES | PLAN INFO | PLAN COST | FAQ'S | DENTISTS | **APPLICATION**

>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

enrollment application for plan 1

FOLLOW THESE SIMPLE DIRECTIONS

1. Complete the information requested about you and your dependents.
2. Include your bank account information for payment.
3. Apply on-line by clicking the SUBMIT button.
4. Please print out a copy of your application for your records.
You will be sent an email confirming receipt of your application.

questions

- Q How long does it take to process my application?
- Q When will I receive my enrollment package and what will it include?
- Q Do the applicant name and the billing name need to be the same?
- Q What if I need to change my membership from Individual to Family Coverage?

ELIGIBILITY

Eligible persons are members of the National Consumer's Advantage Association and their eligible dependents. Age limits for eligible dependent children may vary by state.

EFFECTIVE DATE

If your application and payment information is submitted by the 20th of the month, your coverage will be effective on the 1st of the following month. If it is submitted after the 20th of the month, your coverage will be effective on the 1st of the second following month. The effective date will be shown on your I.D. card issued by the Company

Applicant Information

first name middle initial last name

social security # - -

street address 1

street address 2

city state zip code

daytime phone # - - cell phone # - -

fax # - - email address

will you or any other dependent(s) have other dental insurance coverage? NO YES

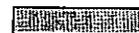
if yes, please list the insurance company name and phone number.

CENSUS

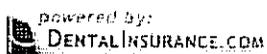
birthday

first name, last name		gender	mm/dd/yyyy	relationship	student
<input type="text"/>	<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	applicant	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/> - <input type="text"/> - <input type="text"/>	>>	>>

Need room for more dependents? click here >>



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plan 1

HIGHLIGHTS FEATURES PLAN INFO PLAN COST FAQ'S DENTISTS **PLAN COST**

>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

Plan Cost and Payment Options

Plan Cost

	MONTHLY	QUARTERLY
INITIAL PLAN COST:	\$18.64	\$55.92
PLUS PROCESSING FEE:*	\$25.00	\$25.00
PLUS BILLING FEE:	\$3.00	\$3.00
PLUS NCAA FEE:	\$1.00	\$3.00
TOTAL AMOUNT DUE:	\$47.64	\$86.92

Payment Options

INITIAL PAYMENT OPTIONS: ACH ACH

ONGOING PAYMENT OPTIONS: ACH ACH

Effective Date

EFFECTIVE DATE: 5/1/2008

* Processing fee is one time non-refundable.



THE COMPANY ACCEPTS THE FOLLOWING PAYMENT TYPES:

INITIAL PAYMENT

Below are the choices for your initial payment.

Monthly E-Check

Quarterly E-Check

ONGOING PAYMENT(S)

Below are the corresponding choices for ongoing payment(s).

Monthly E-Check

Quarterly E-Check

YOUR PAYMENT(S) WILL BE PROCESSED AS FOLLOWS

INITIAL PAYMENT

Monthly E-Check If application is received by the 20th of the month, e-check is drafted on the 25th day of that month.

If application is received after the 20th of the month, e-check is drafted on the 25th day of the following month.

Quarterly E-Check If application is received by the 20th of the month, e-check is drafted on the 25th day of that month.

If application is received after the 20th of the month, e-check is

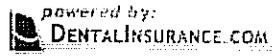
drafted on the 25th day of the following month.

ONGOING PAYMENT

Monthly E-Check Processed on the 25th day of each month.

Quarterly E-Check Processed on the 25th day of the first month of each quarter.

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>> RETURN TO PLAN COMPARISONS

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Initial Payment

MONTHLY ACH

INITIAL ONE MONTH'S PAYMENT:	\$18.64
PLUS PROCESSING FEE:	\$25.00
AND BILLING FEE:	\$3.00
AND NCAA FEE:	\$1.00
TOTAL INITAL PAYMENT:	\$47.64

Ongoing Payment

MONTHLY ACH

ONGOING ONE MONTH'S PAYMENT:	\$18.64
AND BILLING FEE:	\$3.00
AND NCAA FEE:	\$1.00
TOTAL ONGOING PAYMENT:	\$22.64

Payment Information for Bank Account Draft (ACH)

financial institution <input style="width: 100%;" type="text"/>	account type: <input type="radio"/> checking <input type="radio"/> savings
branch name <input style="width: 100%;" type="text"/>	branch phone number <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>
personal routing number <input style="width: 100%;" type="text"/> <small>(First 9 digits found on bottom left corner of deposit slip)</small>	account number <input style="width: 100%;" type="text"/> <small>(4-14 digits, including all zeros, found next to routing number)</small>

ROUTING AND ACCOUNT NUMBERS LOCATIONS :

Check or Deposit Slip

John and Jane Doe 1434 Dental Road Crown Point, IN 46035	9999 Date _____
Pay to the Order of _____	\$ <input style="width: 50px;" type="text"/>
First National Bank of Des Moines 1231 First Web Road Des Moines, IA 50319	
For _____	Dollars
1:1234567891:123 @123456789 9999	
Transit Routing Number Account Number Check Number	

Declaration and Agreements

National Consumer Advantage Association enrollment

I understand that in order to purchase this Dental Insurance plan, I must first become a member of the National Consumer's Advantage Association (NCAA). I understand that NCAA members are entitled to receive Car Rental Discount Coupons, Vision Care Discounts, Travel Club Benefits, and various other consumer and discount materials. Under Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to NCAA, I appoint its President as my proxy to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend. I hereby apply for membership in the National Consumer's Advantage Association. I understand that membership dues are \$1.00 monthly and are to be drafted from my account along with the premium for the dental insurance plan.

I understand that an electronic signature on this Association Enrollment is legal and enforceable. I also understand that any electronic signature to this form operates as my original signature.

* applicant full name

test t test

* applicant full name (re-enter for verification)

Automatic Payment Authorization

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of American National Life Insurance Company of Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of coverage.

Important Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

Acknowledgement and Authorization

I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group dental plan offered by the National Consumer's Advantage Association. I, the undersigned applicant, have personally completed the enrollment application and represent that all answers are true and complete to the best of my knowledge and belief. The statements in this enrollment application are deemed to be representations and not warranties. I understand and agree that the insurance will not take effect unless the enrollment application has been accepted and approved by American National Life Insurance Company of Texas and until the effective date as stated in the Identification card, if issued.

I understand that an electronic signature on this enrollment application is legal and enforceable. I also understand that any electronic signature to this form operates as my original signature.

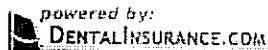
* applicant full name

test t test

* applicant full name (re-enter for verification)



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thank you

your application
has been submitted...

* Note: Once payment is processed and eligibility is confirmed you will be automatically approved for this plan

Please PRINT for your records...

Thank You test test.
Your application for American National Life Insurance Company of Texas Plan 1 has been submitted.

* Please allow 10-14 business days to receive your ID card and package in the mail.

APPLICANT INFORMATION

Applicant Name: test t test
E-mail Address: test@test.com
Address:
111
111, AR 71601
Day Phone: 111-111-1111
Cell Phone: --
Fax: --

CENSUS INFORMATION

test test
applicant

PLAN SUMMARY

Confirmation Number: 77251
Provider: American National Life Insurance Company of Texas
Plan Name: Plan 1
Plan Type: Indemnity
Number of Members: 1

Total Initial Payment: \$47.64 ACH
Total Ongoing Payment: \$22.64 MONTHLY ACH

Requested Effective Date:
05/01/2008

CONTACT INFORMATION

If you have any questions, please see the Frequently Asked Questions.

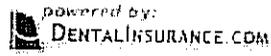
For further questions,
please call American National Life Insurance Company of Texas
Billing at 800-366-5656 ;
or Claims/Eligibility at 800-935-2009 .

Thank you,

DentalInsurance.com
800-296-3800

customersupport@DentalInsurance.com

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plan 2

HIGHLIGHTS FEATURES PLAN INFO PLAN COST FAQ'S DENTISTS **APPLICATION**

>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

enrollment application for plan 2

FOLLOW THESE SIMPLE DIRECTIONS

1. Complete the information requested about you and your dependents.
2. Include your bank account information for payment.
3. Apply on-line by clicking the SUBMIT button.
4. Please print out a copy of your application for your records.
You will be sent an email confirming receipt of your application.

questions

- Q How long does it take to process my application?
- Q When will I receive my enrollment package and what will it include?
- Q Do the applicant name and the billing name need to be the same?
- Q What if I need to change my membership from Individual to Family Coverage?

ELIGIBILITY

Eligible persons are members of the National Consumer's Advantage Association and their eligible dependents. Age limits for eligible dependent children may vary by state.

EFFECTIVE DATE

If your application and payment information is submitted by the 20th of the month, your coverage will be effective on the 1st of the following month. If it is submitted after the 20th of the month, your coverage will be effective on the 1st of the second following month. The effective date will be shown on your I.D. card issued by the Company

Applicant Information

first name middle initial last name

social security # - -

street address 1

street address 2

city state zip code

daytime phone # - - cell phone # - -

fax # - - email address

will you or any other dependent(s) have other dental insurance coverage? NO YES

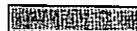
if yes, please list the insurance company name and phone number.

census

birthday

first name, last name		gender	mm/dd/yyyy			relationship	student		
<input type="text"/>	<input type="text"/>	>>	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	applicant	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	>>	>>
<input type="text"/>	<input type="text"/>	>>	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	>>	>>
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Need room for more dependents? click here >>



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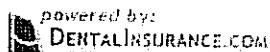
drafted on the 25th day of the following month.

ONGOING PAYMENT

Monthly E-Check Processed on the 25th day of each month.

Quarterly E-Check Processed on the 25th day of the first month of each quarter.

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plan 2

HIGHLIGHTS	FEATURES	PLAN INFO	PLAN COST	FAQ'S	DENTISTS	PLAN COMPARISON
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>> RETURN TO PLAN COMPARISONS

- quote based on 71601 zip code

Initial Payment

MONTHLY ACH

INITIAL ONE MONTH'S PAYMENT:	\$23.50
PLUS PROCESSING FEE:	\$25.00
AND BILLING FEE:	\$3.00
AND NCAA FEE:	\$1.00
TOTAL INITIAL PAYMENT:	\$52.50

Ongoing Payment

MONTHLY ACH

ONGOING ONE MONTH'S PAYMENT:	\$23.50
AND BILLING FEE:	\$3.00
AND NCAA FEE:	\$1.00
TOTAL ONGOING PAYMENT:	\$27.50

Payment Information for Bank Account Draft (ACH)

financial institution <input type="text"/>	account type: <input type="radio"/> checking <input type="radio"/> savings
branch name <input type="text"/>	branch phone number <input type="text"/> - <input type="text"/> - <input type="text"/>
personal routing number <input type="text"/> <small>(First 9 digits found on bottom left corner of deposit slip)</small>	account number <input type="text"/> <small>(4-14 digits, including all zeros, found next to routing number)</small>

ROUTING AND ACCOUNT NUMBERS LOCATIONS :

Check or Deposit Slip

John and Anne Doe 1410 Dental Road Crown Point, IN 46038	Date _____ 9999
Pay to the Order of _____ \$ <input style="width: 50px;" type="text"/>	
<i>Dollars</i>	
First National Bank of Dentistry 1211 First West Road Dental Center, IN 46038	
For _____	
⑆ 123456789 ⑆ 123 ⑆ 12345 ⑆ 11⑆ 9999	
Transit Routing Number	Account Number
	Check Number

Declaration and Agreements

National Consumer Advantage Association enrollment

I understand that in order to purchase this Dental Insurance plan, I must first become a member of the National Consumer's Advantage Association (NCAA). I understand that NCAA members are entitled to receive Car Rental Discount Coupons, Vision Care Discounts, Travel Club Benefits, and various other consumer and discount materials. Under Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to NCAA, I appoint its President as my proxy to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend. I hereby apply for membership in the National Consumer's Advantage Association. I understand that membership dues are \$1.00 monthly and are to be drafted from my account along with the premium for the dental insurance plan.

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* applicant full name

test t test

* applicant full name (re-enter for verification)

Automatic Payment Authorization

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of American National Life Insurance Company of Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of coverage.

Important Fraud Notice

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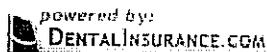
* applicant full name

test t test

* applicant full name (re-enter for verification)



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thank you

your application has been submitted...

* Note: Once payment is processed and eligibility is confirmed you will be automatically approved for this plan

Please PRINT for your records...

Thank You test test.

Your application for American National Life Insurance Company of Texas Plan 2 has been submitted.

* Please allow 10-14 business days to receive your ID card and package in the mail.

APPLICANT INFORMATION

Applicant Name: test t test
E-mail Address: test@test.com
Address:
111
111, AR 71601
Day Phone: 111-111-1111
Cell Phone: --
Fax: --

CENSUS INFORMATION

test test
applicant

PLAN SUMMARY

Confirmation Number: 77252
Provider: American National Life Insurance Company of Texas
Plan Name: Plan 2
Plan Type: Indemnity
Number of Members: 1

Total Initial Payment: \$52.50 ACH
Total Ongoing Payment: \$27.50 MONTHLY ACH

Requested Effective Date:
05/01/2008

CONTACT INFORMATION

If you have any questions, please see the Frequently Asked Questions.

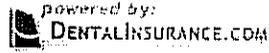
For further questions,
please call American National Life Insurance Company of Texas
Billing at 800-366-5656 ;
or Claims/Eligibility at 800-935-2009 .

Thank you,

DentalInsurance.com
800-296-3800

customersupport@DentalInsurance.com

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