



# Authorization to Release, Obtain and Disclose Information

NF

American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



**This authorization was designed to comply with the requirements of the Health Insurance Portability and Accountability Act.**

I hereby authorize any physician, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, paramedical facility, other medical related facility, information database manager, insurance company, insurance support organization, health plan, group policy holder, benefit plan administrator, employer, state motor vehicle agency, other government agency, consumer reporting agency, and MIB, Inc. to provide the COMPANY, or any employee, representative, affiliate, reinsurer, independent administrator or third party acting on the Company's behalf, any and all information concerning me or any proposed insured, to the extent permitted by state and federal law, including but not limited to:

- entire medical record and any other protected health information;
- diagnosis or treatment of any physical, behavioral or mental condition;
- diagnosis or treatment of any mental illness;
- consultations, surgeries, hospitalizations or confinements;
- HIV, AIDS or ARC related information, including test results;
- serious communicable diseases or infections, including sexually transmitted diseases;
- drug, alcohol or tobacco use;
- consumer reports, including investigative consumer reports;
- driving records; and
- finances, occupations or avocations.

This authorization permits information to be provided electronically, including use of an electronic interchange through a health information exchange, or by access directly to an electronic health record system.

I hereby authorize the COMPANY and its reinsurers to make a brief report of my information to MIB, Inc. I understand that the COMPANY may use or disclose such information to any employee, representative, affiliate, reinsurer, independent administrator or third party for the performance of certain insurance functions including but not limited to underwriting, policy service, claims administration, and compliance; in response to subpoenas or summons; or as otherwise required or permitted by law.

I further understand that:

- (1) I may refuse to sign this authorization and my refusal to sign will affect my ability to obtain life insurance coverage;
- (2) Health care providers or health plans cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization;
- (3) Any agreement to restrict information concerning me or any proposed insured does not apply to this authorization;
- (4) Once information is disclosed under this authorization, it may be redisclosed and no longer be subject to certain state and federal laws;
- (5) A copy of this authorization is as valid as the original;
- (6) I may request a copy of this authorization;
- (7) I may inspect or copy any information used or disclosed under this authorization;
- (8) This authorization is valid from the date signed for a duration of 24 months. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the COMPANY's Service Center, Attn: Life New Business, P.O. Box 3297, Springfield, MO 65899-3297.

_____	X	_____	_____
Name of Proposed Insured	Signature of Proposed Insured	Date of Birth	Date

Check here if you are signing as the parent, guardian or authorized representative of the proposed insured.

**AGENT: EACH PROPOSED INSURED MUST SIGN A SEPARATE AUTHORIZATION.**



# Application for Individual Life Insurance

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Part 1:

Note: Complete and thorough answers to all of the following questions will help to ensure efficient and accurate processing of your application. For any question that requires additional detail, you may attach a sheet of paper, if necessary.

### 1. Primary Proposed Insured

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_

f. Gender:  Male  Female g. Marital Status:  Married  Separated  Single  Widowed  Divorced

h. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

i. Years at this Residence: \_\_\_\_\_ j. Phone Number: Home \_\_\_\_\_ Cell Phone: \_\_\_\_\_ If a phone interview is needed, which is preferred number?  
 Home  Cell

k. Annual Income: \_\_\_\_\_ Net Worth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

l. Occupation/Job Title: \_\_\_\_\_ m. Employer Name: \_\_\_\_\_ n. Type of Business: \_\_\_\_\_

o. Job Duties (Be Specific): \_\_\_\_\_ p. Duration of Employment: \_\_\_\_\_

q. Business Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

r. Are you a U.S. Citizen? .....  Yes  No  
 If No, are you a legal permanent resident of the U.S.? .....  Yes  No  
 If No, do you have a VISA? .....  Yes  No  
 If Yes, type of VISA: \_\_\_\_\_ Expiration date: \_\_\_\_\_  
 If No, please complete Residency Questionnaire.

### 2. Juvenile Primary Proposed Insured (To be completed when Primary Proposed Insured is a juvenile under state law. Do not complete if applying for Children's Term Rider.)

a. Is the owner a parent of the proposed juvenile insured? .....  Yes  No  
 If No, is the owner a grandparent of the proposed juvenile insured? .....  Yes  No  
 If No, is the owner a legally appointed guardian who is responsible for the financial support of the proposed juvenile insured? .....  Yes  No

b. What is the combined annual income and net worth of the proposed juvenile insured's parents (or legally appointed guardian)?  
 Annual Income: \_\_\_\_\_ Net Worth: \_\_\_\_\_  
 \$ \_\_\_\_\_ | \$ \_\_\_\_\_

c. How much Life Insurance does each parent (or legally appointed guardian) have on his/her own life?  
 Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Guardian: \_\_\_\_\_  
 \$ \_\_\_\_\_ | \$ \_\_\_\_\_ | \$ \_\_\_\_\_

d. Are there any other minor siblings in the home? .....  Yes  No  
 If Yes, do the siblings have the same amount of coverage in force/applied for? .....  Yes  No  
 If No, explain: \_\_\_\_\_

e. If the proposed juvenile insured is under the age of 1, was the birth considered premature? .....  Yes  No

f. If the proposed juvenile insured is under the age of 1, what was his or her birth weight? ..... lbs. \_\_\_\_\_ oz.



### 3. Additional Proposed Insured

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_

f. Gender:  Male  Female g. Marital Status:  Married  Separated  Single  Widowed  Divorced

h. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

i. Years at this Residence: \_\_\_\_\_ j. Phone Number: Home \_\_\_\_\_ Cell Phone: \_\_\_\_\_ If a phone interview is needed, which is preferred number?  
\_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_ |  Home  Cell

k. Annual Income: \_\_\_\_\_ Net Worth: \_\_\_\_\_ Relationship to primary proposed insured \_\_\_\_\_  
\$ \_\_\_\_\_ | \$ \_\_\_\_\_ | \_\_\_\_\_

l. Occupation/Job Title: \_\_\_\_\_ m. Employer Name: \_\_\_\_\_ n. Type of Business: \_\_\_\_\_

o. Job Duties (Be Specific): \_\_\_\_\_ p. Duration of Employment: \_\_\_\_\_

q. Business Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

r. Are you a U.S. Citizen?.....  Yes  No  
If No, are you a legal permanent resident of the U.S.?.....  Yes  No  
If No, do you have a VISA?.....  Yes  No  
If Yes, type of VISA: \_\_\_\_\_ . Expiration date: \_\_\_\_\_  
If No, please complete Residency Questionnaire.

### 4. Primary Ownership (if other than Primary Proposed Insured)

#### If owner is an individual:

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Primary Owner to Primary Proposed Insured: \_\_\_\_\_

c. Gender:  Male  Female

d. Date of Birth: Month/Day/Year \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_

f. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
(\_\_\_\_\_) \_\_\_\_\_ | \_\_\_\_\_

#### If owner is a business:

a. Name of Business: \_\_\_\_\_ b. Date Established: \_\_\_\_\_ c. Tax ID Number: \_\_\_\_\_

d. Business Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

#### If owner is a trust:

a. Name of Trust: \_\_\_\_\_ b. Date Trust was created: \_\_\_\_\_

c. Type of Trust:  Revocable  Irrevocable  Qualified Retirement Plan Trust  Other (Explain) \_\_\_\_\_

### 5. Contingent Ownership (Optional ownership, if any)

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Contingent Owner to Primary Proposed Insured: \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Social Security/Tax ID Number: \_\_\_\_\_



**6. Designated Third Party Addressee** *(This person will receive notices for past due premiums and pending policy termination.)*

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
b. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**7. Primary Beneficiary** *(Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life Insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)*

**If beneficiary is an individual:**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

**If beneficiary is a business:**

a. Name of Business: \_\_\_\_\_ b. Date Established: \_\_\_\_\_ c. Tax ID Number: \_\_\_\_\_

**If beneficiary is a trust:**

a. Name of Trust: \_\_\_\_\_ b. Date Trust was created: \_\_\_\_\_  
c. Type of Trust:  Revocable  Irrevocable  Qualified Retirement Plan Trust  Other (Explain) \_\_\_\_\_

**8. Contingent Beneficiary** *(Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)*

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Contingent Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Contingent Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

**9. Children Proposed for Term Rider Coverage**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Proposed Child to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_ f. Gender:  Male  Female

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Proposed Child to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_ f. Gender:  Male  Female



(Continuation of Section 9)

a. Name: Last First M.I. b. Relationship of the Proposed Child to Primary Proposed Insured:
c. Date of Birth: Month/Day/Year d. Age: e. Social Security/Tax ID Number: f. Gender:
g. Has the name of any child age 18 or younger been omitted?
h. If child is under the age of 1, was the birth considered premature?
i. If child is under the age of 1, what was his/her birth weight?
j. Has any child proposed for term rider coverage EVER been diagnosed or treated by a member of the medical profession for any disease or disorder of: the heart; cancer; tumor; seizure disorder/epilepsy; diabetes; respiratory disease; birth defect; psychiatric or behavior abnormality including attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)?

10. Purpose of Coverage (If amount of insurance is greater than \$250,000)

a. If personal coverage: Income Replacement Debt Repayment Estate Planning/Conservation Other
b. If business coverage: Key Person Buy/Sell Deferred Compensation Loan Protection Other

11. Other Insurance and Replacements

a. Do you have existing life insurance or annuity coverage with this, or any other company?
b. If Yes, will the insurance applied for replace, change, or use cash values of any existing life insurance or annuity issued by any company?
c. In the past 6 months, has any proposed insured applied for - or is any proposed insured currently contemplating applying for - other life insurance with this, or any other company?

d. Other Insurance and Replacement Details:
Full Company Name: Policy/Contract Number: Status: Issue Date: Application Date:
Insured/Annuitant's Name: Plan: Amount: Replacement? 1035 Exchange?



## 12. Insurance History and Non-Medical Hazards

- a. In the **past 5 years**, has any proposed insured applied for life, accident, or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn, or modified as to plan, amount, or rate? (If Yes, provide details below.).....  Yes  No
- b. In the **past 5 years**, has any proposed insured engaged in – or within the **next 2 years** does any proposed insured intend to engage in - flights as a pilot, student pilot, crew member, or observer? (If Yes, complete Aviation Questionnaire.).....  Yes  No
- c. In the **past 5 years**, has any proposed insured engaged in - or within the **next 2 years** does any proposed insured intend to engage in - mountain climbing, rock climbing, racing, SCUBA diving, hang gliding, ballooning, or sky diving? (If Yes, complete appropriate questionnaire.)...  Yes  No
- d. In the **past 10 years**, has any proposed insured plead guilty or been convicted of a felony or have any felony charges currently pending? (If Yes, provide details below.).....  Yes  No
- e. In the **past 12 months**, has any proposed insured been or are you currently on probation or parole? (If Yes, provide start and end date.).....  Yes  No
- f. Do you intend to travel or reside outside the U.S. or Canada in the **next 2 years**? .....  Yes  No  
If Yes, where? \_\_\_\_\_

## 13. Driving History

### Primary Proposed Insured:

- a. Do you have a driver's license? .....  Yes  No  
If Yes, what is the driver's license number and issue state?.....DL#: \_\_\_\_\_ State: \_\_\_\_\_  
If No, have you **EVER** had a driver's license? .....  Yes  No
- b. In the **past 5 years**, have you been convicted of any of the following? .....  Yes  No
- driving under the influence or driving while impaired .....  Yes  No  
If Yes, provide date and details regarding sentence: ..... Date: \_\_\_\_\_ Details: \_\_\_\_\_

### Additional Proposed Insured:

- a. Do you have a driver's license? .....  Yes  No  
If Yes, what is the driver's license number and issue state?.....DL#: \_\_\_\_\_ State: \_\_\_\_\_  
If No, have you **EVER** had a driver's license? .....  Yes  No
- b. In the **past 5 years**, have you been convicted of any of the following? .....  Yes  No
- driving under the influence or driving while impaired .....  Yes  No  
If Yes, provide date and details regarding sentence: ..... Date: \_\_\_\_\_ Details: \_\_\_\_\_



**Part 2:**

**14. Physician/Facility that has Most Complete Medical Records on Proposed Insured**

**Primary Proposed Insured:**

a. Physician/Facility Name: \_\_\_\_\_

b. Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ c. Phone: \_\_\_\_\_

d. Date Last Seen: \_\_\_\_\_ e. Reason: \_\_\_\_\_

**Additional Proposed Insured:**

a. Physician/Facility Name: \_\_\_\_\_

b. Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ c. Phone: \_\_\_\_\_

d. Date Last Seen: \_\_\_\_\_ e. Reason: \_\_\_\_\_

**15. Build**

**Primary Proposed Insured:**

a. What is the proposed insured's height and weight? ..... Feet \_\_\_\_\_ Inches \_\_\_\_\_ Pounds \_\_\_\_\_  
b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery? (If Yes, provide details below.) .....  Yes  No

**Additional Proposed Insured:**

a. What is the proposed insured's height and weight? ..... Feet \_\_\_\_\_ Inches \_\_\_\_\_ Pounds \_\_\_\_\_  
b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery? (If Yes, provide details below.) .....  Yes  No

**16. Tobacco Use Information**

**Primary Proposed Insured:**

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? .....  Yes  No  
*If Yes, provide details for all types of nicotine/tobacco used.*

Type: \_\_\_\_\_ Type: \_\_\_\_\_ Type: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Daily  Daily  Daily  
 Occasionally/Socially  Occasionally/Socially  Occasionally/Socially  
 No Longer Use  No Longer Use  No Longer Use  
Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_

**Additional Proposed Insured:**

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? .....  Yes  No  
*If Yes, provide details for all types of nicotine/tobacco used.*

Type: \_\_\_\_\_ Type: \_\_\_\_\_ Type: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Daily  Daily  Daily  
 Occasionally/Socially  Occasionally/Socially  Occasionally/Socially  
 No Longer Use  No Longer Use  No Longer Use  
Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_

**17. Human Immunodeficiency Virus (AIDS)**

(For questions 17 through 21c, provide details in Section 22.)

Has any proposed insured **EVER** been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired immune Deficiency Syndrome (AIDS)? .....  Yes  No



## 18. Medical History - Lifetime

**Has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding...**

- a. Heart disease, including: heart attack; coronary artery blockage; angina; heart failure; cardiomyopathy; irregular heartbeat; or disease or disorder of the heart? .....  Yes  No
- b. Stroke, Transient Ischemic Attack (TIA/mini-stroke), carotid artery disease, peripheral vascular disease, poor circulation, aneurysm, or any other disease or disorder of the blood vessels? .....  Yes  No
- c. Cancer, tumor, abnormal growth, lump, mass, melanoma, lymphoma, or leukemia? .....  Yes  No
- d. Anemia, clotting disorder, or any disease or disorder of the blood? .....  Yes  No
- e. Any diseases or disorders of the immune system except for those related to Human Immunodeficiency Virus (AIDS Virus)? .....  Yes  No

## 19. Medical History - Last 10 Years

**In the past 10 YEARS, has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding...**

- a. High blood pressure? .....  Yes  No
- b. Diabetes or abnormal blood sugar to include high blood sugar or low blood sugar? .....  Yes  No
- c. Depression, anxiety, attention deficit/hyperactivity disorder, bipolar disorder, schizophrenia, post-traumatic stress disorder, or psychiatric treatment? .....  Yes  No
- d. Asthma, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, sleep apnea, tuberculosis, or any disease or disorder of the lungs? .....  Yes  No
- e. Gastrointestinal bleeding, ulcers, Crohn's disease, Barrett's esophagus, ulcerative colitis, hepatitis, cirrhosis, colon polyps, or any other disease or disorder of the esophagus, stomach, intestines/colon, rectum, liver or pancreas? .....  Yes  No
- f. Any disease or disorder of the kidneys, urinary bladder, blood in urine, protein in urine, prostate disorder including abnormal PSA (prostate specific antigen), ovaries, uterus, or cervix including abnormal Pap smear? .....  Yes  No
- g. Disorder of the thyroid, pituitary gland, parathyroid glands, or adrenal glands? .....  Yes  No
- h. Arthritis, fibromyalgia, chronic pain, chronic back pain, or any joint or muscle condition? .....  Yes  No
- i. Lupus, scleroderma, any connective tissue disease, or any autoimmune disorder? .....  Yes  No
- j. Seizures/epilepsy, tremors, multiple sclerosis, paralysis, Alzheimer's, dementia, Parkinson's, blindness or any other disease or disorder of the brain or nervous system? .....  Yes  No

## 20. Drugs/Alcohol History

**In the past 10 YEARS, has any proposed insured...**

- a. Used marijuana in any form? .....  Yes  No
- b. Used cocaine, barbiturates, crack, ecstasy, methamphetamine, heroin, LSD or hallucinogens or any other controlled substance not prescribed by a physician? .....  Yes  No
- c. Been addicted to prescription medication or been advised by a licensed medical professional to discontinue habit forming drugs? .....  Yes  No
- d. Been advised by a licensed medical professional to cease or reduce alcohol use or been advised to get medical treatment, or undergone any medical treatment, counseling, or hospitalization for alcoholism, excessive alcohol use or abuse? .....  Yes  No

## 21. Medical History - Last 5 Years

**In the past 5 YEARS, has any proposed insured...**

- a. Had any consultation, testing, surgery or investigation scheduled or recommended by a member of the medical profession that has not yet been completed (excluding routine checkups, preventative care, pregnancy and HIV)? .....  Yes  No
- b. Applied for or received any disability benefits (other than maternity) from any insurance company, government, employer, or other source? .....  Yes  No
- c. Taken any prescription medications other than what has already been disclosed on the application? .....  Yes  No





## 22. Medical History Explanations

(Give full details below of all Yes answers to questions in Sections 17 through 21.)

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_



**23. Family History** (If amount of insurance is greater than \$100,000)

**Primary Proposed Insured:**

**Father:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma?.....  Yes  No
- If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is father deceased? .....  Yes  No
- If Yes, please indicate cause and age at death: \_\_\_\_\_

**Mother:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma?.....  Yes  No
- If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is mother deceased? .....  Yes  No
- If Yes, please indicate cause and age at death: \_\_\_\_\_

**Siblings:**

- a. How many siblings do you have? ..... \_\_\_\_\_
- b. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma?.....  Yes  No
- If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- c. Are any siblings deceased? .....  Yes  No
- If Yes, please indicate cause and age at death: \_\_\_\_\_

**Additional Proposed Insured:**

**Father:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma?.....  Yes  No
- If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is father deceased? .....  Yes  No
- If Yes, please indicate cause and age at death: \_\_\_\_\_

**Mother:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma?.....  Yes  No
- If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is mother deceased? .....  Yes  No
- If Yes, please indicate cause and age at death: \_\_\_\_\_

**Siblings:**

- a. How many siblings do you have? ..... \_\_\_\_\_
- b. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma?.....  Yes  No
- If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- c. Are any siblings deceased? .....  Yes  No
- If Yes, please indicate cause and age at death: \_\_\_\_\_



### Fraud Statement

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

### Application Signatures

By signing this application I agree to the following:

- I have read the application and all statements and answers as they pertain to me and such statement and answers are true and complete to the best of my knowledge and belief.
- The statements and answers in this application are the basis for and will become part of any policy issued by American National Insurance Company and no information about any person in the application will be considered to have been given to American National Insurance Company unless it is stated in the application.
- If there are any changes in the statements or answers given in this application between the date of application and the delivery of the policy, I am responsible for notifying American National Insurance Company.
- I understand the agent does not have American National Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this application or the policy;
- I understand that American National Insurance Company may issue a policy different than requested in this application subject to my approval and acceptance with the exception that no change in: the amount of insurance; classification; plan of insurance; or benefits will be effective unless I have provided my written consent.
- Only the president, a vice president, or secretary of American National Insurance Company has the authority to waive any of its rights or requirements.
- American National Insurance Company will have no liability until:
  - A policy is issued on this application and delivered to and accepted by the Owner; and
  - The first premium due is paid in full while each proposed insured is alive and in the same health as indicated in this application.
- If Conditional or Premium Receipt was issued:
  - I hereby certify that I have read and received the Conditional or Premium Receipt and agree to its terms.
  - I understand that American National Insurance Company will not permit acceptance of my deposit or issuance of the Conditional or Premium Receipt unless this statement is true.
- I acknowledge that I have received and read the Authorization to Release, Obtain and Disclose Information and authorize American National Insurance Company to obtain personal information about me from the third-party provider(s) explained in the Authorization to Release, Obtain and Disclose Information.
- I understand that federal law requires sufficient information to identify the parties to the purchase of a policy and that failure to provide such information could result in: the policy not being issued; being delayed; unprocessed transaction requests; or policy termination.
- If the Owner is an entity:
  - The individuals signing on behalf of the entity purchasing the policy and are authorized and empowered to individually or collectively:
    - enter into contracts and financial transactions including but not limited to the purchase of life insurance;
    - to make any subsequent withdrawals or surrenders; and
    - exercise all ownership rights under any issued policy in the entity's name.
  - The entity is duly organized and existing in compliance with all laws and regulations.
  - The entity will notify American National Insurance Company in writing of a change in or revocation of authorized individuals, or any change in the entity's status that would cause any of the statements in the application to be incorrect or incomplete.
  - The entity has consulted an independent tax and/or legal advisor for more information deemed necessary to understand the tax treatment of the policy.
  - The authorized individuals and the entity agree to indemnify American National Insurance Company, its affiliates or representatives for liability of any kind arising out of or related to any acts or omissions taken by American National Insurance Company upon their instructions and in reliance on their representatives to American National Insurance Company in connection with the policy.

Date: Month/Day/Year                      Signed at: City    State                      Country

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

Signature of licensed agent    Signature of primary proposed insured (Or guardian, if proposed insured is under the age of majority)

X \_\_\_\_\_ X \_\_\_\_\_

Print agent's name    Signature of additional person proposed for insurance

\_\_\_\_\_ X \_\_\_\_\_

Agent's state license number    Signature of additional person proposed for insurance

\_\_\_\_\_ X \_\_\_\_\_

Agent's company personal code    Signature of owner if other than proposed insured

\_\_\_\_\_ X \_\_\_\_\_

If the owner is a corporation, partnership, or trust, title of the officer is required

\_\_\_\_\_



# Agent's Report

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## 1. Soliciting Agent's Report

I certify that I asked the Proposed Insured(s) each question on the application and accurately recorded each answer provided to me by the Proposed Insured(s).

- a. How long have you personally known the proposed insured? ..... Years \_\_\_\_\_ Months \_\_\_\_\_
- b. By whom will premiums be paid?.....  Owner  Applicant  Other
- c. If beneficiary is not a relative, explain insurable interest. \_\_\_\_\_
- d. Are you aware of anything about the health, habits, hobbies, or other factors that might affect the insurability of the proposed insured? .....  Yes  No  
(If Yes, explain.) \_\_\_\_\_
- e. Did you determine this applicant's objective and/or financial need for this insurance? (If No, explain.) .....  Yes  No  
\_\_\_\_\_
- f. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? .....  Yes  No
- g. As agent, have you complied with state replacement regulations? .....  Yes  No
- h. Have you submitted paperwork for a change in reporting hierarchy or commission arrangement for this application? .....  Yes  No  
If Yes, please describe change: \_\_\_\_\_ New Upline: \_\_\_\_\_

Dated at: City \_\_\_\_\_ Month/Day/Year: \_\_\_\_\_

Corporation Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Branch Office Number and PSO Code: \_\_\_\_\_ Agent Personal Code or Number: \_\_\_\_\_ CSSD District Code 2: \_\_\_\_\_ Agency #: \_\_\_\_\_

Licensed Agent's Signature: \_\_\_\_\_ Agent E-mail Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

X \_\_\_\_\_ | \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_

## 2. Special Issue Instructions to Administrative Office

- a. Additional Policy?..... Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_
- b. Alternate Policy?..... Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_
- c. Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National? .....  Yes  No
- d. Are any other applications being submitted on the proposed insured's family members or business partners that need to be held and issued together? (If Yes, provide names and date of birth.).....  Yes  No  
\_\_\_\_\_
- e. Are commissions to be split? .....  Yes  No  
(If Yes, and split 50/50, list both agents' names and personal code number. If Not, complete and submit the Split Credit Authorization form.)  
Agent: \_\_\_\_\_ Personal code or number: \_\_\_\_\_  
Agent: \_\_\_\_\_ Personal code or number: \_\_\_\_\_
- f. Special Instructions: \_\_\_\_\_

## 3. Notes to Underwriter

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 4. Requirements Ordered: See Current Underwriting Guidelines

- Indicate which of the following was (were) ordered by producer, agency, or general agent:
- Oral Fluid Test collected by agent? Date Collected: \_\_\_\_\_ Lab ticket attached or affix barcode here: \_\_\_\_\_
  - Automatic exam/lab requirements?
- Name of approved paramed company? \_\_\_\_\_
- Were medical records (APS) ordered by producer, agency or general agent? .....  Yes  No  
If Yes, give physician/facility's name: \_\_\_\_\_  
If the medical records have been paid for, attach invoice.



# Application for Individual Life Insurance

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Part 1:

Note: Complete and thorough answers to all of the following questions will help to ensure efficient and accurate processing of your application. For any question that requires additional detail, you may attach a sheet of paper, if necessary.

### 1. Primary Proposed Insured

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_

f. Gender:  Male  Female g. Marital Status:  Married  Separated  Single  Widowed  Divorced

h. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

i. Years at this Residence: \_\_\_\_\_ j. Phone Number: Home \_\_\_\_\_ Cell Phone: \_\_\_\_\_ If a phone interview is needed, which is preferred number?  
 Home  Cell

k. Annual Income: \_\_\_\_\_ Net Worth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

l. Occupation/Job Title: \_\_\_\_\_ m. Employer Name: \_\_\_\_\_ n. Type of Business: \_\_\_\_\_

o. Job Duties (Be Specific): \_\_\_\_\_ p. Duration of Employment: \_\_\_\_\_

q. Business Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

r. Are you a U.S. Citizen? .....  Yes  No  
 If No, are you a legal permanent resident of the U.S.? .....  Yes  No  
 If No, do you have a VISA? .....  Yes  No  
 If Yes, type of VISA: \_\_\_\_\_ Expiration date: \_\_\_\_\_  
 If No, please complete Residency Questionnaire.

### 2. Juvenile Primary Proposed Insured (To be completed when Primary Proposed Insured is a juvenile under state law. Do not complete if applying for Children's Term Rider.)

a. Is the owner a parent of the proposed juvenile insured? .....  Yes  No  
 If No, is the owner a grandparent of the proposed juvenile insured? .....  Yes  No  
 If No, is the owner a legally appointed guardian who is responsible for the financial support of the proposed juvenile insured? .....  Yes  No

b. What is the combined annual income and net worth of the proposed juvenile insured's parents (or legally appointed guardian)?  
 Annual Income: \_\_\_\_\_ Net Worth: \_\_\_\_\_  
 \$ \_\_\_\_\_ | \$ \_\_\_\_\_

c. How much Life Insurance does each parent (or legally appointed guardian) have on his/her own life?  
 Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Guardian: \_\_\_\_\_  
 \$ \_\_\_\_\_ | \$ \_\_\_\_\_ | \$ \_\_\_\_\_

d. Are there any other minor siblings in the home? .....  Yes  No  
 If Yes, do the siblings have the same amount of coverage in force/applied for? .....  Yes  No  
 If No, explain: \_\_\_\_\_

e. If the proposed juvenile insured is under the age of 1, was the birth considered premature? .....  Yes  No

f. If the proposed juvenile insured is under the age of 1, what was his or her birth weight? ..... lbs. \_\_\_\_\_ oz.



**3. Additional Proposed Insured**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_

f. Gender:  Male  Female g. Marital Status:  Married  Separated  Single  Widowed  Divorced

h. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

i. Years at this Residence: \_\_\_\_\_ j. Phone Number: Home \_\_\_\_\_ Cell Phone: \_\_\_\_\_ If a phone interview is needed, which is preferred number?  
 \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_ |  Home  Cell

k. Annual Income: \_\_\_\_\_ Net Worth: \_\_\_\_\_ Relationship to primary proposed insured \_\_\_\_\_  
 \$ \_\_\_\_\_ | \$ \_\_\_\_\_ | \_\_\_\_\_

l. Occupation/Job Title: \_\_\_\_\_ m. Employer Name: \_\_\_\_\_ n. Type of Business: \_\_\_\_\_

o. Job Duties (Be Specific): \_\_\_\_\_ p. Duration of Employment: \_\_\_\_\_

q. Business Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

r. Are you a U.S. Citizen?.....  Yes  No  
 If No, are you a legal permanent resident of the U.S.? .....  Yes  No  
 If No, do you have a VISA? .....  Yes  No  
 If Yes, type of VISA: \_\_\_\_\_ . Expiration date: \_\_\_\_\_ .  
 If No, please complete Residency Questionnaire.

**4. Primary Ownership (if other than Primary Proposed Insured)**

**If owner is an individual:**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Primary Owner to Primary Proposed Insured: \_\_\_\_\_

c. Gender:  Male  Female

d. Date of Birth: Month/Day/Year \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_

f. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_ | \_\_\_\_\_

**If owner is a business:**

a. Name of Business: \_\_\_\_\_ b. Date Established: \_\_\_\_\_ c. Tax ID Number: \_\_\_\_\_

d. Business Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**If owner is a trust:**

a. Name of Trust: \_\_\_\_\_ b. Date Trust was created: \_\_\_\_\_

c. Type of Trust:  Revocable  Irrevocable  Qualified Retirement Plan Trust  Other (Explain) \_\_\_\_\_

**5. Contingent Ownership (Optional ownership, if any)**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Contingent Owner to Primary Proposed Insured: \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Social Security/Tax ID Number: \_\_\_\_\_



**6. Designated Third Party Addressee** (This person will receive notices for past due premiums and pending policy termination.)

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
b. Residence Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**7. Primary Beneficiary** (Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life Insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)

**If beneficiary is an individual:**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

**If beneficiary is a business:**

a. Name of Business: \_\_\_\_\_ b. Date Established: \_\_\_\_\_ c. Tax ID Number: \_\_\_\_\_

**If beneficiary is a trust:**

a. Name of Trust: \_\_\_\_\_ b. Date Trust was created: \_\_\_\_\_  
c. Type of Trust:  Revocable  Irrevocable  Qualified Retirement Plan Trust  Other (Explain) \_\_\_\_\_

**8. Contingent Beneficiary** (Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Contingent Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Contingent Beneficiary to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Gender:  Male  Female e. Social Security/Tax ID Number: \_\_\_\_\_ f. Percentage Payable: \_\_\_\_\_ %

**9. Children Proposed for Term Rider Coverage**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Proposed Child to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_ f. Gender:  Male  Female

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Proposed Child to Primary Proposed Insured: \_\_\_\_\_  
c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_ f. Gender:  Male  Female



**(Continuation of Section 9)**

a. Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship of the Proposed Child to Primary Proposed Insured: \_\_\_\_\_

c. Date of Birth: Month/Day/Year \_\_\_\_\_ d. Age: \_\_\_\_\_ e. Social Security/Tax ID Number: \_\_\_\_\_ f. Gender:  Male  Female

g. Has the name of any child age 18 or younger been omitted?.....  Yes  No  
If Yes, explain. \_\_\_\_\_

h. If child is under the age of 1, was the birth considered premature?.....  Yes  No  
If Yes, how many weeks premature?..... \_\_\_\_\_ weeks  
Duration of hospitalization?..... \_\_\_\_\_ weeks

i. If child is under the age of 1, what was his/her birth weight?..... \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

j. Has any child proposed for term rider coverage **EVER** been diagnosed or treated by a member of the medical profession for any disease or disorder of: the heart; cancer; tumor; seizure disorder/epilepsy; diabetes; respiratory disease; birth defect; psychiatric or behavior abnormality including attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)? (If Yes, provide details below, including child's name and disease or disorder.).....  Yes  No

\_\_\_\_\_

\_\_\_\_\_

**10. Purpose of Coverage** (If amount of insurance is greater than \$250,000)

a. If personal coverage:  Income Replacement  Debt Repayment  Estate Planning/Conservation  Other \_\_\_\_\_

b. If business coverage:  Key Person  Buy/Sell  Deferred Compensation  Loan Protection  
 Other \_\_\_\_\_

**11. Other Insurance and Replacements**

a. Do you have existing life insurance or annuity coverage with this, or any other company?  
(If Yes, complete Other Insurance and Replacement Details.).....  Yes  No

b. If Yes, will the insurance applied for replace, change, or use cash values of any existing life insurance or annuity issued by any company?  
(If Yes, complete Other Insurance and Replacement Details.).....  Yes  No

c. In the **past 6 months**, has any proposed insured applied for - or is any proposed insured currently contemplating applying for - other life insurance with this, or any other company? (If Yes, state how much and to whom.).....  Yes  No

d. Other Insurance and Replacement Details:

Full Company Name: \_\_\_\_\_ Policy/Contract Number: \_\_\_\_\_ Status:  Life  Annuity  In Force  Pending Issue Date: \_\_\_\_\_ Application Date: \_\_\_\_\_

Insured/Annuitant's Name: \_\_\_\_\_ Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Replacement?  Yes  No 1035 Exchange?  Yes  No

---

Full Company Name: \_\_\_\_\_ Policy/Contract Number: \_\_\_\_\_ Status:  Life  Annuity  In Force  Pending Issue Date: \_\_\_\_\_ Application Date: \_\_\_\_\_

Insured/Annuitant's Name: \_\_\_\_\_ Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Replacement?  Yes  No 1035 Exchange?  Yes  No

---

Full Company Name: \_\_\_\_\_ Policy/Contract Number: \_\_\_\_\_ Status:  Life  Annuity  In Force  Pending Issue Date: \_\_\_\_\_ Application Date: \_\_\_\_\_

Insured/Annuitant's Name: \_\_\_\_\_ Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Replacement?  Yes  No 1035 Exchange?  Yes  No





## 12. Insurance History and Non-Medical Hazards

- a. In the **past 5 years**, has any proposed insured applied for life, accident, or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn, or modified as to plan, amount, or rate? (If Yes, provide details below.).....  Yes  No
- b. In the **past 5 years**, has any proposed insured engaged in – or within the **next 2 years** does any proposed insured intend to engage in - flights as a pilot, student pilot, crew member, or observer? (If Yes, complete Aviation Questionnaire.).....  Yes  No
- c. In the **past 5 years**, has any proposed insured engaged in - or within the **next 2 years** does any proposed insured intend to engage in - mountain climbing, rock climbing, racing, SCUBA diving, hang gliding, ballooning, or sky diving? (If Yes, complete appropriate questionnaire.)...  Yes  No
- d. In the **past 10 years**, has any proposed insured plead guilty or been convicted of a felony or have any felony charges currently pending? (If Yes, provide details below.).....  Yes  No
- e. In the **past 12 months**, has any proposed insured been or are you currently on probation or parole? (If Yes, provide start and end date.).....  Yes  No
- f. Do you intend to travel or reside outside the U.S. or Canada in the **next 2 years**? .....  Yes  No  
If Yes, where? \_\_\_\_\_

## 13. Driving History

### Primary Proposed Insured:

- a. Do you have a driver's license? .....  Yes  No  
If Yes, what is the driver's license number and issue state?.....DL#: \_\_\_\_\_ State: \_\_\_\_\_  
If No, have you **EVER** had a driver's license? .....  Yes  No
- b. In the **past 5 years**, have you been convicted of any of the following? .....  Yes  No
- driving under the influence or driving while impaired .....  Yes  No  
If Yes, provide date and details regarding sentence: ..... Date: \_\_\_\_\_ Details: \_\_\_\_\_

### Additional Proposed Insured:

- a. Do you have a driver's license? .....  Yes  No  
If Yes, what is the driver's license number and issue state?.....DL#: \_\_\_\_\_ State: \_\_\_\_\_  
If No, have you **EVER** had a driver's license? .....  Yes  No
- b. In the **past 5 years**, have you been convicted of any of the following? .....  Yes  No
- driving under the influence or driving while impaired .....  Yes  No  
If Yes, provide date and details regarding sentence: ..... Date: \_\_\_\_\_ Details: \_\_\_\_\_



**Part 2:**

**14. Physician/Facility that has Most Complete Medical Records on Proposed Insured**

**Primary Proposed Insured:**

a. Physician/Facility Name: \_\_\_\_\_

b. Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ c. Phone: \_\_\_\_\_

d. Date Last Seen: \_\_\_\_\_ e. Reason: \_\_\_\_\_

**Additional Proposed Insured:**

a. Physician/Facility Name: \_\_\_\_\_

b. Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ c. Phone: \_\_\_\_\_

d. Date Last Seen: \_\_\_\_\_ e. Reason: \_\_\_\_\_

**15. Build**

**Primary Proposed Insured:**

a. What is the proposed insured's height and weight? ..... Feet \_\_\_\_\_ Inches \_\_\_\_\_ Pounds \_\_\_\_\_  
b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery? (If Yes, provide details below.) .....  Yes  No

**Additional Proposed Insured:**

a. What is the proposed insured's height and weight? ..... Feet \_\_\_\_\_ Inches \_\_\_\_\_ Pounds \_\_\_\_\_  
b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery? (If Yes, provide details below.) .....  Yes  No

**16. Tobacco Use Information**

**Primary Proposed Insured:**

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? .....  Yes  No  
*If Yes, provide details for all types of nicotine/tobacco used.*

Type: \_\_\_\_\_ Type: \_\_\_\_\_ Type: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Daily  Daily  Daily  
 Occasionally/Socially  Occasionally/Socially  Occasionally/Socially  
 No Longer Use  No Longer Use  No Longer Use  
Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_

**Additional Proposed Insured:**

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? .....  Yes  No  
*If Yes, provide details for all types of nicotine/tobacco used.*

Type: \_\_\_\_\_ Type: \_\_\_\_\_ Type: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Daily  Daily  Daily  
 Occasionally/Socially  Occasionally/Socially  Occasionally/Socially  
 No Longer Use  No Longer Use  No Longer Use  
Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_ Date of Last Use: \_\_\_\_\_

**17. Human Immunodeficiency Virus (AIDS)**

(For questions 17 through 21c, provide details in Section 22.)

Has any proposed insured **EVER** been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired immune Deficiency Syndrome (AIDS)? .....  Yes  No



## 18. Medical History - Lifetime

**Has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding...**

- a. Heart disease, including: heart attack; coronary artery blockage; angina; heart failure; cardiomyopathy; irregular heartbeat; or disease or disorder of the heart? .....  Yes  No
- b. Stroke, Transient Ischemic Attack (TIA/mini-stroke), carotid artery disease, peripheral vascular disease, poor circulation, aneurysm, or any other disease or disorder of the blood vessels? .....  Yes  No
- c. Cancer, tumor, abnormal growth, lump, mass, melanoma, lymphoma, or leukemia? .....  Yes  No
- d. Anemia, clotting disorder, or any disease or disorder of the blood? .....  Yes  No
- e. Any diseases or disorders of the immune system except for those related to Human Immunodeficiency Virus (AIDS Virus)? .....  Yes  No

## 19. Medical History - Last 10 Years

**In the past 10 YEARS, has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding...**

- a. High blood pressure? .....  Yes  No
- b. Diabetes or abnormal blood sugar to include high blood sugar or low blood sugar? .....  Yes  No
- c. Depression, anxiety, attention deficit/hyperactivity disorder, bipolar disorder, schizophrenia, post-traumatic stress disorder, or psychiatric treatment? .....  Yes  No
- d. Asthma, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, sleep apnea, tuberculosis, or any disease or disorder of the lungs? .....  Yes  No
- e. Gastrointestinal bleeding, ulcers, Crohn's disease, Barrett's esophagus, ulcerative colitis, hepatitis, cirrhosis, colon polyps, or any other disease or disorder of the esophagus, stomach, intestines/colon, rectum, liver or pancreas? .....  Yes  No
- f. Any disease or disorder of the kidneys, urinary bladder, blood in urine, protein in urine, prostate disorder including abnormal PSA (prostate specific antigen), ovaries, uterus, or cervix including abnormal Pap smear? .....  Yes  No
- g. Disorder of the thyroid, pituitary gland, parathyroid glands, or adrenal glands? .....  Yes  No
- h. Arthritis, fibromyalgia, chronic pain, chronic back pain, or any joint or muscle condition? .....  Yes  No
- i. Lupus, scleroderma, any connective tissue disease, or any autoimmune disorder? .....  Yes  No
- j. Seizures/epilepsy, tremors, multiple sclerosis, paralysis, Alzheimer's, dementia, Parkinson's, blindness or any other disease or disorder of the brain or nervous system? .....  Yes  No

## 20. Drugs/Alcohol History

**In the past 10 YEARS, has any proposed insured...**

- a. Used marijuana in any form? .....  Yes  No
- b. Used cocaine, barbiturates, crack, ecstasy, methamphetamine, heroin, LSD or hallucinogens or any other controlled substance not prescribed by a physician? .....  Yes  No
- c. Been addicted to prescription medication or been advised by a licensed medical professional to discontinue habit forming drugs? .....  Yes  No
- d. Been advised by a licensed medical professional to cease or reduce alcohol use or been advised to get medical treatment, or undergone any medical treatment, counseling, or hospitalization for alcoholism, excessive alcohol use or abuse? .....  Yes  No

## 21. Medical History - Last 5 Years

**In the past 5 YEARS, has any proposed insured...**

- a. Had any consultation, testing, surgery or investigation scheduled or recommended by a member of the medical profession that has not yet been completed (excluding routine checkups, preventative care, pregnancy and HIV)? .....  Yes  No
- b. Applied for or received any disability benefits (other than maternity) from any insurance company, government, employer, or other source? .....  Yes  No
- c. Taken any prescription medications other than what has already been disclosed on the application? .....  Yes  No



## 22. Medical History Explanations

(Give full details below of all Yes answers to questions in Sections 17 through 21.)

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Question: Person: \_\_\_\_\_ Reason, Condition, Disease, Injury, Medication(s), Etc.: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_ Attending Physician Address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_



**23. Family History** (If amount of insurance is greater than \$100,000)

**Primary Proposed Insured:**

**Father:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma?.....  Yes  No
  - If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is father deceased? .....  Yes  No
  - If Yes, please indicate cause and age at death: \_\_\_\_\_

**Mother:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma?.....  Yes  No
  - If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is mother deceased? .....  Yes  No
  - If Yes, please indicate cause and age at death: \_\_\_\_\_

**Siblings:**

- a. How many siblings do you have? ..... \_\_\_\_\_
- b. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma?.....  Yes  No
  - If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- c. Are any siblings deceased? .....  Yes  No
  - If Yes, please indicate cause and age at death: \_\_\_\_\_

**Additional Proposed Insured:**

**Father:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma?.....  Yes  No
  - If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is father deceased? .....  Yes  No
  - If Yes, please indicate cause and age at death: \_\_\_\_\_

**Mother:**

- a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma?.....  Yes  No
  - If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- b. Is mother deceased? .....  Yes  No
  - If Yes, please indicate cause and age at death: \_\_\_\_\_

**Siblings:**

- a. How many siblings do you have? ..... \_\_\_\_\_
- b. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma?.....  Yes  No
  - If Yes, please indicate condition and age at diagnosis: \_\_\_\_\_
- c. Are any siblings deceased? .....  Yes  No
  - If Yes, please indicate cause and age at death: \_\_\_\_\_



**Fraud Statement**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Application Signatures**

By signing this application I agree to the following:

- I have read the application and all statements and answers as they pertain to me and such statement and answers are true and complete to the best of my knowledge and belief.
- The statements and answers in this application are the basis for and will become part of any policy issued by American National Insurance Company and no information about any person in the application will be considered to have been given to American National Insurance Company unless it is stated in the application.
- If there are any changes in the statements or answers given in this application between the date of application and the delivery of the policy, I am responsible for notifying American National Insurance Company.
- I understand the agent does not have American National Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this application or the policy;
- I understand that American National Insurance Company may issue a policy different than requested in this application subject to my approval and acceptance with the exception that no change in: the amount of insurance; classification; plan of insurance; or benefits will be effective unless I have provided my written consent.
- Only the president, a vice president, or secretary of American National Insurance Company has the authority to waive any of its rights or requirements.
- American National Insurance Company will have no liability until:
  - A policy is issued on this application and delivered to and accepted by the Owner; and
  - The first premium due is paid in full while each proposed insured is alive and in the same health as indicated in this application.
- If Conditional or Premium Receipt was issued:
  - I hereby certify that I have read and received the Conditional or Premium Receipt and agree to its terms.
  - I understand that American National Insurance Company will not permit acceptance of my deposit or issuance of the Conditional or Premium Receipt unless this statement is true.
- I acknowledge that I have received and read the Authorization to Release, Obtain and Disclose Information and authorize American National Insurance Company to obtain personal information about me from the third-party provider(s) explained in the Authorization to Release, Obtain and Disclose Information.
- I understand that federal law requires sufficient information to identify the parties to the purchase of a policy and that failure to provide such information could result in: the policy not being issued; being delayed; unprocessed transaction requests; or policy termination.
- If the Owner is an entity:
  - The individuals signing on behalf of the entity purchasing the policy and are authorized and empowered to individually or collectively:
    - enter into contracts and financial transactions including but not limited to the purchase of life insurance;
    - to make any subsequent withdrawals or surrenders; and
    - exercise all ownership rights under any issued policy in the entity's name.
  - The entity is duly organized and existing in compliance with all laws and regulations.
  - The entity will notify American National Insurance Company in writing of a change in or revocation of authorized individuals, or any change in the entity's status that would cause any of the statements in the application to be incorrect or incomplete.
  - The entity has consulted an independent tax and/or legal advisor for more information deemed necessary to understand the tax treatment of the policy.
  - The authorized individuals and the entity agree to indemnify American National Insurance Company, its affiliates or representatives for liability of any kind arising out of or related to any acts or omissions taken by American National Insurance Company upon their instructions and in reliance on their representatives to American National Insurance Company in connection with the policy.

Date: Month/Day/Year                      Signed at: City    State      Country

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

Signature of licensed agent    Signature of primary proposed insured (Or guardian, if proposed insured is under the age of majority)

X \_\_\_\_\_    X \_\_\_\_\_

Print agent's name    Signature of additional person proposed for insurance

\_\_\_\_\_    X \_\_\_\_\_

Agent's state license number    Signature of additional person proposed for insurance

\_\_\_\_\_    X \_\_\_\_\_

Agent's company personal code    Signature of owner if other than proposed insured

\_\_\_\_\_    X \_\_\_\_\_

If the owner is a corporation, partnership, or trust, title of the officer is required



# Agent's Report

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## 1. Soliciting Agent's Report

I certify that I asked the Proposed Insured(s) each question on the application and accurately recorded each answer provided to me by the Proposed Insured(s).

- a. How long have you personally known the proposed insured? ..... Years \_\_\_\_\_ Months \_\_\_\_\_
- b. By whom will premiums be paid?.....  Owner  Applicant  Other
- c. If beneficiary is not a relative, explain insurable interest. \_\_\_\_\_
- d. Are you aware of anything about the health, habits, hobbies, or other factors that might affect the insurability of the proposed insured? .....  Yes  No  
(If Yes, explain.) \_\_\_\_\_
- e. Did you determine this applicant's objective and/or financial need for this insurance? (If No, explain.) .....  Yes  No  
\_\_\_\_\_
- f. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? .....  Yes  No
- g. As agent, have you complied with state replacement regulations? .....  Yes  No
- h. Have you submitted paperwork for a change in reporting hierarchy or commission arrangement for this application? .....  Yes  No  
If Yes, please describe change: \_\_\_\_\_ New Upline: \_\_\_\_\_

Dated at: City \_\_\_\_\_ Month/Day/Year: \_\_\_\_\_

Corporation Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Branch Office Number and PSO Code: \_\_\_\_\_ Agent Personal Code or Number: \_\_\_\_\_ CSSD District Code 2: \_\_\_\_\_ Agency #: \_\_\_\_\_

Licensed Agent's Signature: \_\_\_\_\_ Agent E-mail Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

X \_\_\_\_\_ | \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_

## 2. Special Issue Instructions to Administrative Office

- a. Additional Policy?..... Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_
- b. Alternate Policy?..... Plan: \_\_\_\_\_ Amount: \$ \_\_\_\_\_
- c. Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National? .....  Yes  No
- d. Are any other applications being submitted on the proposed insured's family members or business partners that need to be held and issued together? (If Yes, provide names and date of birth.).....  Yes  No  
\_\_\_\_\_
- e. Are commissions to be split? .....  Yes  No  
(If Yes, and split 50/50, list both agents' names and personal code number. If Not, complete and submit the Split Credit Authorization form.)  
Agent: \_\_\_\_\_ Personal code or number: \_\_\_\_\_  
Agent: \_\_\_\_\_ Personal code or number: \_\_\_\_\_
- f. Special Instructions: \_\_\_\_\_

## 3. Notes to Underwriter

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 4. Requirements Ordered: See Current Underwriting Guidelines

- Indicate which of the following was (were) ordered by producer, agency, or general agent:
- Oral Fluid Test collected by agent? Date Collected: \_\_\_\_\_ Lab ticket attached or affix barcode here: \_\_\_\_\_
  - Automatic exam/lab requirements?
- Name of approved paramed company? \_\_\_\_\_
- Were medical records (APS) ordered by producer, agency or general agent? .....  Yes  No  
If Yes, give physician/facility's name: \_\_\_\_\_  
If the medical records have been paid for, attach invoice.



# Supplemental Application for Signature Term Life An Individual Nonparticipating Term Life Product

F

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Product Selections

Please select the plan applied for below:

- Signature Term Annual Renewable Term
- Signature Term 10-Year Level Term
- Signature Term 15-Year Level Term
- Signature Term 20-Year Level Term
- Signature Term 30-Year Level Term

Amount of Insurance \$ \_\_\_\_\_  
(Minimum of \$50,000)

## Optional Riders / Benefits *(Additional costs may apply.)*

- Children's Term Rider .....\$ \_\_\_\_\_  
*Complete Section 9 of Application.*
- Disability Waiver of Premium Rider

## Premium

Planned Premium Amount.....\$ \_\_\_\_\_

## Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

- Do not change the Premium Amount; change the Amount of Insurance.
- Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_

## Important Notice

**You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.**





# Supplemental Application for Universal Life

## An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product

F

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



### Product Selections

Please select the plan applied for below:

- Executive Universal Life

Specified Amount of Insurance \$ \_\_\_\_\_

(Minimum of \$25,000)

Life Insurance Qualification Test:

- Guideline Premium Test ("GPT")

### Death Benefit Option (Must select one)

- Option A - Specified Amount
- Option B - Specified Amount plus Accumulation Value
- Option C - Specified Amount plus Return of Premiums

### Optional Riders / Benefits (Additional costs may apply.)

#### Executive Universal Life

- Children's Term Rider ..... \$ \_\_\_\_\_  
*Complete Section 9 of Application.*
- Disability Waiver of Minimum Premium Rider  
*(May not be combined with any other disability waiver of premium.)*
- Disability Waiver of Stipulated Premium Rider ..... \$ \_\_\_\_\_  
*(May not be combined with any other disability waiver of premium.)*
- Guaranteed Increase Option Rider ..... \$ \_\_\_\_\_  
*(\$10,000 - \$25,000 in \$1,000 increments.)*

### Premium

Planned Periodic Premium Amount.....\$ \_\_\_\_\_

Initial Premium (if different than Planned Periodic Premium Amount).....\$ \_\_\_\_\_

- Check here if initial premium will be applied from a 1035 Exchange.

### Special Requests

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_

### Important Notice

**You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.**



Supplemental Application for Indexed Universal Life Series
An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012



Product Selections

Please select the plan applied for below:

- Signature Performance Indexed Universal Life
Signature Performance Indexed Universal Life Unisex (457 plans)

Amount of Insurance \$
(Minimum of \$25,000)

Life Insurance Qualification Test:
Guideline Premium Test ("GPT")

Death Benefit Option (Must select one)

- Option A - Specified Amount
Option B - Specified Amount plus Accumulation Value
Option C - Specified Amount plus Return of Premiums

Premium Allocation

All crediting strategies have a one-year term. Indexed Crediting Strategies are based on the Declared Index. When allocating premiums, whole percentages must be used and the total must equal 100%.

Table with columns for crediting strategies and percentages. Includes Fixed Account, Indexed Crediting Strategies (S&P 500, S&P MARC, NASDAQ-100, etc.), and Total (must equal 100%).

Optional Riders / Benefits (Additional costs may apply.)

Signature Performance Indexed Universal Life

- Children's Term Rider
Disability Waiver of Minimum Premium Rider
Disability Waiver of Stipulated Premium Rider
Guaranteed Increase Option Rider

Signature Performance Indexed Universal Life Unisex

- Disability Waiver of Minimum Premium Rider
Disability Waiver of Stipulated Premium Rider

Premium

Planned Premium Amount
Initial Premium (if different than Planned Premium Amount)
Check here if initial premium will be applied from a 1035 Exchange.



## Special Requests

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_

## Important Notice

**You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.**

**By signing this application, I agree to the following:**

- I am applying for an indexed life insurance policy.
- The interest credited to the policy may be affected by the performance of an index. This does not mean the return will equal that of the index.
- The policy does not directly participate in any stock or equity investments or index; I am not buying ownership interest in any stock or index.
- I understand that the guaranteed interest rate credited to any available index fund will never be less than 0%.



# Supplemental Application for Signature Guaranteed Universal Life An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product

F

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Product Selections

Please select the plan applied for below:

Signature Guaranteed Universal Life

Amount of Insurance \$ \_\_\_\_\_  
(Minimum of \$25,000)

Life Insurance Qualification Test:

Cash Value Accumulation Test ("CVAT")

## Death Benefit Option

Option A - Specified Amount

## Duration of Death Benefit Guarantee

- Coverage to 95
- Coverage to 100
- Other Age \_\_\_\_\_
- Coverage to 105
- Coverage to 121

## Optional Riders / Benefits *(Additional costs may apply.)*

- Children's Term Rider ..... \$ \_\_\_\_\_  
*Complete Section 9 of Application.*
- Disability Waiver of Stipulated Premium ..... \$ \_\_\_\_\_

## Premium

Planned Premium Amount ..... \$ \_\_\_\_\_

Initial Premium Amount (if different than Planned Premium Amount) ..... \$ \_\_\_\_\_

Check here if initial premium will be applied from a 1035 Exchange.

## Special Requests

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_

## Important Notice

**You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.**



# Supplemental Application for Signature Whole Life An Individual Participating Whole Life Insurance Product

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Product Selections

Please select the plan applied for below:

Signature Whole Life

Amount of Insurance \$ \_\_\_\_\_  
(Minimum of \$10,000)

Automatic Premium Loan Requested?  Yes  No

## Dividend Options (Must select one)

Cash  Premium Reduction\*  Participating Paid-Up Additions  Dividend Accumulation

\*Only available with Direct Billing.

If Premium Reduction is selected, You must specify a secondary option:

Cash  Dividend Accumulation  Participating Paid-Up Additions

## Optional Riders / Benefits (Additional costs may apply.)

Children's Term Rider ..... \$ \_\_\_\_\_

Complete Section 9 of Application.

Disability Waiver of Premium Rider

Guaranteed Insurance Option Rider ..... \$ \_\_\_\_\_

Paid-Up Additions Rider

**Planned Modal Premium** ..... \$ \_\_\_\_\_

No. of Years ..... \_\_\_\_\_

OR Single Premium ..... \$ \_\_\_\_\_

Signature Term Rider ..... \$ \_\_\_\_\_

Level Term Period:

ART  10 Year  15 Year  20 Year  30 Year

(Minimum \$25,000 - Maximum 4x base policy)

Name of Proposed Rider Insured: \_\_\_\_\_

Is the Beneficiary for this rider the same as the Beneficiary for the policy?.....  Yes  No

If No, please complete the Additional Beneficiary Page and submit with application.

## Premium

Planned Premium Amount ..... \$ \_\_\_\_\_

Initial Premium (if different than Planned Premium Amount) ..... \$ \_\_\_\_\_

Check here if initial premium will be applied from a 1035 Exchange.

## Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

Do not change the Premium Amount; change the Amount of Insurance.

Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_



# Supplemental Application for Limited Pay Whole Life An Individual Non-Participating Whole Life Insurance Product

F

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Product Selections

Please select the plan applied for below:

- Limited Pay Whole Life
- Product to be used in a group retirement plan  
(not including 457/403b market)

Amount of Insurance \$ \_\_\_\_\_  
(Minimum of \$10,000)

## Optional Riders / Benefits (Additional costs may apply.)

- Disability Waiver of Premium Rider

## Premium

Planned Premium Amount.....\$ \_\_\_\_\_

Initial Premium (if different than Planned Premium Amount).....\$ \_\_\_\_\_

- Check here if initial premium will be applied from a 1035 Exchange.

## Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

- Do not change the Premium Amount; change the Amount of Insurance.
- Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_



**Supplemental Application for Indexed Universal Life Series**  
**An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product**

F

Issued by American National Insurance Company  
 One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297  
 Business: (800) 899-6806 Fax: (888) 237-1012



**Product Selections**

Please select the plan applied for below:

Signature Protection Index Universal Life

Amount of Insurance \$ \_\_\_\_\_  
 (Minimum of \$250,000)

Life Insurance Qualification Test:

- Cash Value Accumulation Test ("CVAT")
- Guideline Premium Test ("GPT")

**Death Benefit Option (Must select one)**

- Option A - Specified Amount
- Option B - Specified Amount plus Accumulation Value

**Duration of Death Benefit Guarantee**

Age \_\_\_\_\_

**Premium Allocation**

All crediting strategies have a one-year term. Indexed Crediting Strategies are based on the Declared Index. When allocating premiums, whole percentages must be used and the total must equal 100%.

Fixed Account .....	_____ %
Indexed Crediting Strategies:	
S&P 500® Index Point to Point Uncapped with Interest Rate Spread.....	_____ %
S&P 500® Index Point to Point with Cap.....	_____ %
S&P MARC 5% Excess Return Index Point to Point Uncapped .....	_____ %
NASDAQ-100 Index® Point to Point with Cap .....	_____ %
<b>Total (must equal 100%) .....</b>	<b>_____ %</b>

**Optional Riders / Benefits (Additional costs may apply.)**

**Signature Protection Indexed Universal Life**

- Children's Term Rider ..... \$ \_\_\_\_\_  
*Complete Section 9 on Application.*
- Disability Waiver of Stipulated Premium Rider ..... \$ \_\_\_\_\_

**Premium**

Planned Premium Amount (if different than above) ..... \$ \_\_\_\_\_  
 Initial Premium (if different than Planned Periodic Premium Amount)..... \$ \_\_\_\_\_  
 Check here if initial premium will be applied from a 1035 Exchange.

**Special Requests**

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_



## **Important Notice**

**You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.**

**By signing this application, I agree to the following:**

- **I am applying for an indexed life insurance policy.**
- **The interest credited to the policy may be affected by the performance of an index. This does not mean the return will equal that of the index.**
- **The policy does not directly participate in any stock or equity investments or index; I am not buying ownership interest in any stock or index.**
- **I understand that the guaranteed interest rate credited to any available index fund will never be less than 0%.**





# Billing Information

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## 1. Billing Data

### a. Premium Billing Mode (select one):

- Annual
- Semiannual
- Quarterly
- Monthly
- Single Premium
- Bi Weekly (Salary Deduction Only)

### b. Premium Payment Method (select one):

- Electronic Fund Transfer (EFT)** – (Choose an option below and complete Section 2)

- Draft upon approval and receipt of all outstanding policy requirements. If this option is selected, the effective date of coverage will become the draft date.
- Draft on specific day (1-28) \_\_\_\_\_, after approval and receipt of all outstanding policy requirements. Day specified will determine policy effective date.

- Direct Bill (Monthly Mode not available)**

Fill in name and address where premium notices are to be sent, only if other than the owner.

Name: \_\_\_\_\_

Number/Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

Country: \_\_\_\_\_

- Salary Deduction / Franchise / Government Allotment**

Premium amount based on Mode selected above \$ \_\_\_\_\_

Payee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Franchise Number: \_\_\_\_\_

### c. E-mail Address of Premium Payer: \_\_\_\_\_

## 2. Electronic Fund Transfer (EFT) Information: Attach "VOID" Check

Name of premium payer: \_\_\_\_\_

Name(s) of insured(s): \_\_\_\_\_

Account type:  Checking  Savings

Bank name: \_\_\_\_\_ Bank account number: \_\_\_\_\_ Bank transit number: \_\_\_\_\_

Bank address: Number/Street \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

The undersigned requests the above-named bank to honor debit entries, either by electronic or paper means, to my account and payable to American National Insurance Company of Galveston, Texas. I agree that there will be no liability, on your part, for any reason whatsoever, for payment or failure to pay any such debit item. If, at any time, I do not have on deposit, in said bank, available funds sufficient to pay such debits, the pre-authorized payment privilege shall be automatically discontinued. Premiums then due or becoming due thereafter must be paid in accordance with one of the other methods of premium payment available to the policyowner. It is understood and agreed that all debit entries are accepted by the Company subject to their being honored upon presentation.

Date: Month/Day/Year \_\_\_\_\_

Signature of premium payer \_\_\_\_\_

X \_\_\_\_\_

Signature of Agent \_\_\_\_\_

X \_\_\_\_\_



# Authorization to Release, Obtain and Disclose Information

NF

American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



**This authorization was designed to comply with the requirements of the Health Insurance Portability and Accountability Act.**

I hereby authorize any physician, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, paramedical facility, other medical related facility, information database manager, insurance company, insurance support organization, health plan, group policy holder, benefit plan administrator, employer, state motor vehicle agency, other government agency, consumer reporting agency, and MIB, Inc. to provide the COMPANY, or any employee, representative, affiliate, reinsurer, independent administrator or third party acting on the Company's behalf, any and all information concerning me or any proposed insured, to the extent permitted by state and federal law, including but not limited to:

- entire medical record and any other protected health information;
- diagnosis or treatment of any physical, behavioral or mental condition;
- diagnosis or treatment of any mental illness;
- consultations, surgeries, hospitalizations or confinements;
- HIV, AIDS or ARC related information, including test results;
- serious communicable diseases or infections, including sexually transmitted diseases;
- drug, alcohol or tobacco use;
- consumer reports, including investigative consumer reports;
- driving records; and
- finances, occupations or avocations.

This authorization permits information to be provided electronically, including use of an electronic interchange through a health information exchange, or by access directly to an electronic health record system.

I hereby authorize the COMPANY and its reinsurers to make a brief report of my information to MIB, Inc. I understand that the COMPANY may use or disclose such information to any employee, representative, affiliate, reinsurer, independent administrator or third party for the performance of certain insurance functions including but not limited to underwriting, policy service, claims administration, and compliance; in response to subpoenas or summons; or as otherwise required or permitted by law.

I further understand that:

- (1) I may refuse to sign this authorization and my refusal to sign will affect my ability to obtain life insurance coverage;
- (2) Health care providers or health plans cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization;
- (3) Any agreement to restrict information concerning me or any proposed insured does not apply to this authorization;
- (4) Once information is disclosed under this authorization, it may be redisclosed and no longer be subject to certain state and federal laws;
- (5) A copy of this authorization is as valid as the original;
- (6) I may request a copy of this authorization;
- (7) I may inspect or copy any information used or disclosed under this authorization;
- (8) This authorization is valid from the date signed for a duration of 24 months. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the COMPANY's Service Center, Attn: Life New Business, P.O. Box 3297, Springfield, MO 65899-3297.

	X		
Name of Proposed Insured	Signature of Proposed Insured	Date of Birth	Date

Check here if you are signing as the parent, guardian or authorized representative of the proposed insured.

**AGENT: EACH PROPOSED INSURED MUST SIGN A SEPARATE AUTHORIZATION.**



## Consumer Disclosure

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF



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Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297 Business: (800) 899-6806 Fax: (888) 237-1012

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### MIB / FCRA PRE-NOTIFICATION

**AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED(S).**

#### **MIB, Inc. Pre-Notification**

Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s), however, may make a brief report of such information to the MIB, Inc. (MIB). MIB is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such company, MIB will supply such company with information in your file upon request.

At your request, MIB will arrange disclosure of information in your file. If you question the accuracy of such information, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. MIB's telephone number is 866-692-6901 (TTY 866-346-3642), and its mailing address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The American National Insurance Company or its reinsurer(s) may also release information in your file to other insurance companies to whom you apply for life or health insurance coverage or to whom a claim for benefits is submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

#### **Fair Credit Report Act Pre-Notification**

We may request a consumer report, including an investigative consumer report, in connection with this application for insurance. In addition, such a report may be requested in the future to update our records or if you apply for additional coverage. The report may include information about your character, general reputation, personal characteristics or mode of living and may involve personal interviews with neighbors, friends, employers, business associates, financial sources, friends, neighbors or others with whom you are acquainted.

You have the right to request a written summary of your rights under the federal Fair Credit Reporting Act. You also have the right to make a written request within a reasonable period of time for a complete and accurate disclosure regarding the nature and scope of the requested investigation. Upon written request, we will disclose whether an investigative consumer report was requested as well as the name and address of the consumer reporting agency to whom the request was made. By contacting the agency, you may inspect and receive a copy of the report.



# Conditional Receipt

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



Policy No. \_\_\_\_\_

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL INSURANCE COMPANY.  
DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

I have received \$ \_\_\_\_\_ in connection with an application for life insurance bearing the same serial number as this receipt. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

- (1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
- (2) All medical examinations and tests required under the company's initial application requirements must be completed and the reports of those medical examinations and tests must be received at the company's home office within 45 days after the date of this receipt;
- (3) On the effective date, as defined below, all persons proposed for insurance must be in good health and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
- (4) There is no material misrepresentation in the application.

**MAXIMUM AMOUNT LIMITATION:** At no time and in no event shall the total liability of the company under this receipt and all other receipts providing conditional insurance coverage with the company on the lives of all the persons proposed for insurance exceed \$500,000.

**EFFECTIVE DATE MEANS THE LATEST OF:** (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

**REFUND OF PAYMENT:** If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the company's liability is limited to a refund of the amount paid. Only the president, a vice president or secretary of the company has the authority to waive any of the company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

Date: Month/Day/Year	Signed at: City	State	Country
_____	_____	_____	_____

Signature of licensed agent  
X \_\_\_\_\_

I have read this conditional receipt. It has been explained to me by the agent.

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)  
X \_\_\_\_\_

Signature of Owner  
X \_\_\_\_\_



## Summary and Disclosure Notice for Accelerated Benefits

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF

page 1 of 3



**THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE ACCELERATED BENEFIT RIDERS LISTED BELOW. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY EACH RIDER.**

**Your policy may contain some or all of the Accelerated Benefit Riders described in this summary and disclosure notice. You should check Your policy to determine which, if any, of these riders have been attached to Your policy. You may request a full or partial Accelerated Benefit. Payment of a full Accelerated Benefit means that Your Base Policy or Covered Rider(s), for which the full Accelerated Benefit is paid, will terminate. If you request a partial Accelerated Benefit, then all coverages eligible for acceleration will be reduced by the percentage of Accelerated Benefit requested. The death benefit that would have been paid to the Beneficiary after the death of the Rider Insured will be paid to You prior to the death of the Rider Insured. You will not receive the full death benefit, but rather a reduced amount called the Accelerated Benefit Payment.**

**Receipt of an Accelerated Benefit may be a taxable event. You should consult a tax advisor regarding the tax status of any benefit paid to You under this Rider. Receipt of Accelerated Benefits may affect your eligibility for Medicaid, supplemental security income, or other government benefits or entitlements.**

In order to receive Accelerated Benefits, You must request the payment of a full or partial Accelerated Benefit and show proof that the Rider Insured has met the qualifying conditions of one of the Accelerated Benefit Riders, as described below.

There is no additional premium required for these Riders.

An administrative fee, not to exceed \$500, will be deducted from the Accelerated Benefit Payment.

**Accelerated Benefit Rider for Terminal Illness** – Covers an illness or chronic condition that is reasonably expected to result in the death of the Rider Insured within 24 months or less.

**Accelerated Benefit Rider for Chronic Illness** – Covers an illness or physical condition in which the Rider Insured:

- a. is unable to perform at least two (2) Activities of Daily Living, without Substantial Assistance from another person, due to a loss of functional capacity for a period of at least ninety (90) days; or,
- b. requires supervision by another person to protect the Rider Insured from threats to health and safety due to the Rider Insured's Severe Cognitive Impairment.

The Activities of Daily Living are bathing, continence, dressing, eating, toileting and transferring.

**Severe Cognitive Impairment** – Severe Cognitive Impairment is the deterioration or loss of intellectual capacity that is:

- a. comparable to, and includes, Alzheimer's Disease and similar forms of irreversible dementia; and,
- b. measured by clinical evidence and standardized tests which reliably measure impairment in, short term or long term memory, orientation to people, places, or time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

**Accelerated Benefit Rider for Critical Illness** – Critical Illness means the Rider Insured has experienced one of the following Qualifying Events:

- a. **Heart Attack** (myocardial infarction) – The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart Attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. The diagnosis of a Heart Attack must be made by a Physician board certified in Cardiology and based on the presence of:
  1. associated new EKG changes which support the diagnosis; and,
  2. elevation of cardiac enzymes above standard laboratory levels.
- b. **Stroke** – A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis resulting in paralysis or other measurable neurological deficit which persists for 96 hours following the occurrence of the Stroke. Stroke does not include transient ischemic attacks. The diagnosis of a Stroke must be made by a Physician board certified in Neurology.



- c. **Invasive Cancer** – A disease which is characterized by the presence and uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Invasive Cancer must be diagnosed by a pathological or clinical diagnosis. Invasive Cancer does not include:
1. any skin cancer, except invasive malignant melanoma into the dermis or deeper;
  2. pre malignant lesions, benign tumors, or polyps;
  3. early prostate cancer diagnosed as T1N0M0 or equivalent staging; or,
  4. carcinoma in situ.
- d. **Diagnosis of End Stage Renal Failure** – The irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.
- e. **Major Organ Transplant** – The receipt by transplant of any of the following organs or tissues; heart, lung, liver, kidney, pancreas, small intestine or bone marrow. The Rider Insured must be registered on the United Network of Organ Sharing.
- f. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis)** by a qualified Physician.
- g. **Blindness** – The total and permanent loss of sight in both eyes as a result of disease or injury and results in a reduced life expectancy. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.
- h. **Paralysis** – The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days. Paralysis must be confirmed by a Physician board certified in Neurology.
- i. **Arterial Aneurysms** – A localized widening (dilatation) of an artery, vein, or the heart. The diagnosis of an Arterial Aneurysm must be made by a Physician board certified in Cardiology.
- j. **Central Nervous System Tumors** – Diagnosis of any abnormal solid growth involving the central nervous system (brain and/or spinal cord) by a Physician.
- k. **Major Multi System Trauma** – Any major accident or injury resulting in significant alteration of any three (3) body systems which requires hospitalization and extended rehabilitation, results in permanent impairment of the function and/or altered ability to perform Activities of Daily Living, and significantly alters the Rider Insured's life expectancy.
- l. **Auto Immune Deficiency Syndrome (AIDS)** – Advanced HIV infection that is associated with an AIDS defining condition (P. carinii pneumonia, esophageal candidiasis, wasting, Kaposi's sarcoma, disseminated mycobacterium avium infection, tuberculosis, cytomegalovirus disease, HIV associated dementia, recurrent bacterial pneumonia, toxoplasmosis, immunoblastic lymphoma, chronic cryptosporidiosis, Burkitt lymphoma, disseminated histoplasmosis, invasive cervical cancer and chronic herpes simplex) and has been diagnosed by a Physician.
- m. **Severe Disease of Any Organ** – Severe Disease of Any Organ system is any illness that is life threatening, requires inpatient hospital care and, and will significantly alter the Rider Insured's life expectancy, as diagnosed by a Physician.
- n. **Severe Central Nervous System Disease** – Severe disease of the central nervous system, brain and/or spinal cord, as diagnosed by a Physician that is life threatening and significantly alters the Rider Insured's life expectancy, as diagnosed by a Physician. Severe Central Nervous System Disease includes, but is not limited to, progressive multiple sclerosis, Parkinson's Disease, Huntington's chorea and encephalitis which permanently alters a portion of the cerebrum.
- o. **Major Burns** – The diagnosis by a Physician board certified in plastic surgery, that the Rider Insured has sustained third degree burns covering at least 40% of the surface area of the Rider Insured's body.
- p. **Loss of Limbs** – The complete and permanent severance of two or more limbs through or above the elbow or knee joint due to trauma or accident and results in a reduced life expectancy. Loss of Limbs as a result of disease process is excluded from this definition.

No Accelerated Benefit will be paid under any Accelerated Benefit Rider for Critical Illness for any Qualifying Event that occurs before the date of issue of the Base Policy to which this Rider is attached.

No Accelerated Benefit will be paid under any Accelerated Benefit Rider for a condition that results from any self inflicted injury or attempted suicide.



The Accelerated Benefit will be paid to you in lieu of all or a portion of the Eligible Death Benefit. The Eligible Death Benefit is the total amount of death benefit available for acceleration under the base policy and any Covered Riders. The Accelerated Benefit Payment will be equal to the Eligible Death Benefit less the actuarial discount, as determined by Us; an administrative charge not to exceed \$500; and any policy debt, if the qualifying Rider Insured is also the Base Policy Insured. The Accelerated Benefit Payment for the Base Policy Insured will never be less than the cash surrender value of the Base Policy, if any.

You may choose to receive the Accelerated Benefit Payment in a lump sum or a series of periodic payments. If You elect periodic payments, You may apply the Accelerated Benefit Payment to any non life contingent Settlement Option pursuant to the Settlement Options provision of the Base Policy.

If an Accelerated Benefit is elected for the Base Policy Insured, any Rider attached to the Base Policy will be treated as if the Base Policy Insured has died. Acceleration of a Covered Rider will be treated as though the Rider Insured has died for the purpose of determining the impact of the acceleration on the Base Policy.

**I acknowledge that I have reviewed this Summary and Disclosure Notice and have been provided a copy for my records.**

\_\_\_\_\_

Owner

\_\_\_\_\_

Date

\_\_\_\_\_

Agent

\_\_\_\_\_

Date



# Supplemental Application for Signature Term Life An Individual Nonparticipating Term Life Product

F

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297  
Business: (800) 899-6806 Fax: (888) 237-1012



## Product Selections

Please select the plan applied for below:

- Signature Term Annual Renewable Term
- Signature Term 10-Year Level Term
- Signature Term 15-Year Level Term
- Signature Term 20-Year Level Term
- Signature Term 30-Year Level Term

Amount of Insurance \$ \_\_\_\_\_  
(Minimum of \$50,000)

## Optional Riders / Benefits *(Additional costs may apply.)*

- Children's Term Rider .....\$ \_\_\_\_\_  
*Complete Section 9 of Application.*
- Disability Waiver of Premium Rider

## Premium

Planned Premium Amount.....\$ \_\_\_\_\_

## Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

- Do not change the Premium Amount; change the Amount of Insurance.
- Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_

## Important Notice

**You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.**





## **PART A - NOTICE AND CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS/AIDS-RELATED TESTING**

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

F

page 1 of 3



### **READ THIS NOTICE VERY CAREFULLY**

To evaluate your insurability, the Insurer has asked that you provide a sample of your blood, oral fluid taken from your cheek and gum tissue, or urine for testing to determine the presence of human immunodeficiency virus (HIV) antibodies. It may be necessary to provide a sample of more than one of these bodily fluids. A test is considered positive if two ELISA (enzyme-linked immunosorbent assay) blood or other bodily fluid tests are positive, confirmed by the Western Blot blood or other bodily fluid test. These tests may be replaced in the future with new and more effective tests. Other tests which may be performed include blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders. These tests are extremely accurate. Further information about HIV testing and AIDS can be obtained by calling the National AIDS Hotline at 1-800-342-2437.

#### **AIDS:**

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by the HIV virus. The virus is transmitted:

- by sexual contact with an infected person
- from an infected mother to her newborn infant
- by exposure to infected blood through shared needles during drug use
- through a blood transfusion

Persons at high risk of contracting AIDS include males who have had sexual contact with another male, drug users who share needles, those whose blood doesn't clot properly, and sexual contacts of any of these persons. In some people, the virus reduces the body's normal defenses against certain diseases or infections. As a result, such people often develop such unusual conditions as severe pneumonia or a rare skin cancer.

The symptoms of AIDS may include the following:

- unexplained weight loss
- persistent night sweats
- cough
- shortness of breath
- diarrhea
- white spots evidencing fungal infection
- fever
- swollen lymph nodes lasting more than one month
- raised purple spots on or under the skin or on mucous membranes

AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain symptom free for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

#### **PRE-TESTING CONSIDERATIONS**

Many public health organizations have suggested that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

#### **MEANING OF POSITIVE TEST RESULT**

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, which causes AIDS. It shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS, but that you are at a significantly higher risk of developing problems with your immune system. Persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Medical treatment should be sought for the HIV infection and any related infections, as this is a lifelong infection. Responsibility should be taken to prevent knowingly infecting others. Safe sex practices should be performed; drug use with shared needles should be avoided to prevent spread of the infection. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Possible errors include:



## **PART A - (continued)**

1. False positives - The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behaviors. Retesting should be done to help confirm the validity of the positive test.
2. False negatives - The test gives a negative result, even though you are infected with HIV. This is most likely to happen in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will negatively affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

### **CONFIDENTIALITY OF TEST RESULTS**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. The organizations described above may maintain the test results in a file or data bank. Positive HIV and hepatitis antibody/antigen tests will be reported to your State Department of Health if the laboratory or the insurance company are required or permitted to do so by law.

### **NOTIFICATION OF TEST RESULTS**

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician on the Notice and Consent form so that the Insurer can have him or her tell you the test result and explain its meaning.



# PART B - NOTICE AND CONSENT FOR BLOOD OR OTHER BODY FLUIDS AIDS-RELATED TESTING

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947



**Read this notice very carefully.  
Do not sign it unless it is completely filled out and you have read and understood it.**

I have received, read, and understand the Notice and Consent For Human Immunodeficiency Virus/AIDS-Related Testing ("Part A"). I voluntarily consent to the collection/withdrawal of blood, oral fluid from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described in Part A. I have read and understand the information provided to me about what a positive test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or facsimile of this form will be as valid as the original.

Examiner \_\_\_\_\_

Insurer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### NAME AND ADDRESS OF PHYSICIAN FOR REPORTING A POSSIBLE POSITIVE TEST RESULT:

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

If you want to know the results of the test but do not at present have a private physician, the result will be sent to you at the address provided below. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Proposed Insured Printed Name \_\_\_\_\_

Proposed Insured or Parent/Guardian-Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian-Printed Name (if applicable) \_\_\_\_\_

Date \_\_\_\_\_



## Consumer Disclosure

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF



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Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297 Business: (800) 899-6806 Fax: (888) 237-1012

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### MIB / FCRA PRE-NOTIFICATION

**AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED(S).**

#### **MIB, Inc. Pre-Notification**

Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s), however, may make a brief report of such information to the MIB, Inc. (MIB). MIB is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such company, MIB will supply such company with information in your file upon request.

At your request, MIB will arrange disclosure of information in your file. If you question the accuracy of such information, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. MIB's telephone number is 866-692-6901 (TTY 866-346-3642), and its mailing address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The American National Insurance Company or its reinsurer(s) may also release information in your file to other insurance companies to whom you apply for life or health insurance coverage or to whom a claim for benefits is submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

#### **Fair Credit Report Act Pre-Notification**

We may request a consumer report, including an investigative consumer report, in connection with this application for insurance. In addition, such a report may be requested in the future to update our records or if you apply for additional coverage. The report may include information about your character, general reputation, personal characteristics or mode of living and may involve personal interviews with neighbors, friends, employers, business associates, financial sources, friends, neighbors or others with whom you are acquainted.

You have the right to request a written summary of your rights under the federal Fair Credit Reporting Act. You also have the right to make a written request within a reasonable period of time for a complete and accurate disclosure regarding the nature and scope of the requested investigation. Upon written request, we will disclose whether an investigative consumer report was requested as well as the name and address of the consumer reporting agency to whom the request was made. By contacting the agency, you may inspect and receive a copy of the report.



# Acknowledgement in Lieu of Illustration Submission

NF

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

page 1 of 2

- American National Insurance Company
- American National Life Insurance Company of Texas



**Please complete and sign *either* Section A *or* Section B.**

## A. Certification and Acknowledgement of Computer Screen Illustration

I acknowledge that I viewed a computer screen illustration and that no hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that I displayed a computer screen illustration for \_\_\_\_\_ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_; Age: \_\_\_\_\_

Underwriting or Rating Class: \_\_\_\_\_

Type of Policy: \_\_\_\_\_

Initial Death Benefit: \$ \_\_\_\_\_

Dividend Option (if applicable): \_\_\_\_\_

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_



**B. Acknowledgement That No Illustration Was Provided**

I acknowledge that I have not received an illustration that matches the policy I am applying for. I further acknowledge that an illustration conforming to the policy as issued will be provided to me to sign no later than at the time of delivery.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_



# Deduction Agreement

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

NF

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- American National Insurance Company
- American National Life Insurance Company of Texas



No.: \_\_\_\_\_  
(Home Office Use Only)

### Employer or Organization Information:

Name to Appear on Bill: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Billing lists will be sent to the employer or organization directly. Note: Must have a minimum of 10 policies to be put on List Bill. If less than 10 policies we will bill you using our combined billing method of pay.

Please complete the following questions regarding payroll deduction and requested bill date. (Select **one** for each option.):

1. Franchise Payroll Deduction Date:  1<sup>st</sup>  15<sup>th</sup>  28<sup>th</sup>
2. Billing Mode:  Monthly  Quarterly  Semi-Annual  Annual

Until further notice, the employer or organization agrees to honor the written request of its employees, members, or depositors for deduction from their accounts, salaries, or wages of monthly premiums on policies issued by the American National Insurance Company (hereinafter called the Company) and to forward such deductions to the Company.

The employer or organization agrees to make deductions according to the schedule established with the Company and to remit all deductions to the Company or its designated agent on the due date.

The employer or organization assumes no other liability under this agreement, and this agreement will continue in force until 30 days after the Company receives written notice of termination from the employer or organization, together with payment of all deductions up to the date of termination. After that date, the employer or organization will have no further responsibility for deductions and each employee, member, or depositor will be responsible for making arrangements with the Company for payments. The employer or organization will not make further deductions for any employee, member, or depositor after that person terminates his or her relationship with the employer or organization.

The employer or organization will accept authorization cards signed by the employee, member, or depositor as complete authorization for deductions to be made, and no further notice or authorization will be required from either the employee, member, or depositor or the Company.

Franchise Representative Signature: \_\_\_\_\_ Date: Month/Day/Year  
X \_\_\_\_\_

Franchise Representative – Print Name: \_\_\_\_\_

Soliciting Agent Signature: \_\_\_\_\_ Date: Month/Day/Year  
X \_\_\_\_\_

Soliciting Agent – Print Name: \_\_\_\_\_

Branch Office, PSO Code: \_\_\_\_\_



# Important Notice: Replacement of Life Insurance or Annuities

F

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

page 1 of 4

- American National Insurance Company
- American National Life Insurance Company of Texas



Do you have existing insurance or annuity coverage?

No; **It is not necessary** to complete the rest of this form. Please sign here.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date

Yes; please continue.

This document must be signed by the applicant and the agent, a copy left with the applicant, and a copy included with the application forwarded to the Home Office.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. **You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost.** A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on pages 3 and 4 of this form.

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)

1.  Yes  No Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
2.  Yes  No Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?

If answer to both questions above is, "No", it is not necessary to complete the remaining pages of this form. Please sign below.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date





If you answered "yes" to either of the questions 1 or 2 on the bottom of page 1, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1. _____			
2. _____			
3. _____			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary, or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

**SPECIFIC REASON FOR REPLACING EXISTING POLICY WITH NEW PROPOSED POLICY: You SHOULD NOT take action to terminate, assign or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you.**

Remember, where a replacement is involved, the policy owner has the right to return the policy within thirty (30) days of delivery of the contract and receive a full refund of all premiums.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:



**PREMIUMS:**

Are they affordable?

Could they change?

Are they guaranteed on your current policy?

You're older - are premiums higher for the proposed new policy? On the old policy?

How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:**

Does your current policy pay dividends?

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

**INSURABILITY:**

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations and contestable periods may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?



## IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

Do you know the Guaranteed and Current Interest Rates for your current policy and the proposed new policy?

Have you compared the contract charges or other policy expenses?

## OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

### Statement of Policy Regarding Replacements

**Producers should not advise, suggest, or recommend that an existing life insurance policy or annuity contract be replaced unless it is in the interest of the customer.**

I certify that only American National approved sales materials were used in my sales presentation, and copies of all materials used were given to the applicant. I also attest that I have been made aware of the Company policy regarding replacements, and I believe this proposed replacement falls within that policy.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date

This is to acknowledge that I have reviewed and jointly completed this Replacement Questionnaire with the agent proposing my new policy. After considering all of the factors that relate to my personal situation, I believe it to be in my best interest to replace my current policy with the proposed new policy.

I certify that the responses herein are, to the best of my knowledge, accurate (see acknowledgement).

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date

**INSTRUCTIONS TO PRODUCER: All pages of this form are to be completed in their entirety when a new ANICO/ANTEX policy is being issued to replace either another ANICO/ANTEX or another company's policy.**



# Pre-Authorized Payment Plan - Authorization Form

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7947

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- American National Insurance Company
- American National Life Insurance Company of Texas



### Bank Account Information:

The undersigned account holder requests that policy premiums specified below be paid by electronic debit by the bank named in this request. If at any time funds in my account are insufficient to pay these debits, the pre-authorized payment privilege will be automatically discontinued. Premiums then due or becoming due thereafter must be paid in accordance with one of the other methods of premium payment available. I understand and agree that all debits are accepted by the Company subject to their being honored upon presentation.

Transit Number								Account Number																Account Type														
																		Checking	Savings																			

Print Name of Bank Account Holder \_\_\_\_\_

Signature of Bank Account Holder \_\_\_\_\_

Signature of Joint Bank Account Holder \_\_\_\_\_

Bank \_\_\_\_\_ Branch \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### Policy Information: Policy Numbers

\_\_\_\_\_  
\_\_\_\_\_

### Premium Section: Used only for Flexible Premium policies

- I authorize American National Insurance Company to debit \$ \_\_\_\_\_ from the above named bank for premiums.  
 Monthly     Quarterly     Semiannually     Annually

### Scheduled Loan Repayment: Used only if policy currently has an outstanding loan

- I authorize American National Insurance Company to deduct \$ \_\_\_\_\_ monthly for my scheduled loan repayment.  
 (Minimum \$15.00)

### Authorization to draft all premiums due section:

I authorize American National Insurance Company to debit my account for all premiums necessary to pay my policy current.

- Check if a payment is enclosed.

Insured Name \_\_\_\_\_ Date \_\_\_\_\_

Owner/Controller Name \_\_\_\_\_ Owner/Controller Signature \_\_\_\_\_

Joint Owner Name \_\_\_\_\_ Joint Owner Signature \_\_\_\_\_

**PLEASE ATTACH A "VOID" SPECIMEN OF CHECK IN THE SPACE PROVIDED.**  
**USE ADHESIVE TAPE**  
**DO NOT STAPLE OR GLUE**  
**ENSURE THAT ALL EDGES ARE TAPED SECURELY BEFORE SCANNING**