



Supplemental Life Application Initial Premium Allocations for Signature Series Index Universal Life

F

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

page 1 of 1

Policy Number: _____



OWNER

Name: Last _____ First _____ M.I. _____

Daytime telephone _____ Owner's Email _____

(____) _____ | _____

INSURED

Name: Last _____ First _____ M.I. _____

Daytime telephone _____ Insured's Email _____

(____) _____ | _____

PRODUCT INFORMATION

IMPORTANT: Ensure you receive the correct Signature IUL Product by entering either Signature IUL or Signature Plus IUL on the Product Information Section of the Application for Life Insurance.

CREDITING STRATEGIES

All Crediting Strategies have a one year term. Indexed Crediting Strategies are based on the Declared Index. Whole percentages must be used. Percentages must be the same as those listed in the Application for Life Insurance, if any.

	Percentage
Fixed Account	_____
Point to Point with Specified Rate	_____
Point to Point with Cap	_____
Point to Point with Cap and Higher Floor	_____
Point to Point Uncapped with Interest Rate Spread	_____
Total (must equal 100%)	_____

FRAUD WARNING

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

SIGNATURES

When you buy this Indexed Universal Life Insurance policy, you are not buying an ownership interest in any stock or index. Interest earnings are paid at a rate that is related to the performance of the Declared Index. The index does not reflect dividends paid on the stocks underlying the index. Past performance of the index is no guarantee of future results.

Signature of Owner _____ Date _____

Signature of Agent _____ Date _____ Agent's Email _____

Printed Agent's Name _____ Date _____ Agent's Phone Number _____



Tips for Completing the Life Application (Form 10193)

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

- American National Insurance Company (ANICO)
- American National Life Insurance Company of Texas (ANTEX)

This instruction section is not part of the application.

General Instructions

- **Answer all questions on each page in complete detail using blue or black ink**
- **The following questions are often overlooked or incomplete; please pay careful attention.**

Section 1

j: Have you ever used tobacco or nicotine in any form?
(e.g. cigarettes, cigars, chewing tobacco, etc.)

t: US Citizen verification

Section 10

a: Do you have existing life insurance or annuity coverage?

b: Will the insurance applied for replace or use cash values....?

c: Total Insurance/Annuities in force on Proposed Insured....”

Section 13

a: Family physician, specialist or clinic of proposed insured

Section 14

a: Is any proposed insured taking any medication(s)?

Section 18

a-n: Insurance History and Non-Medical Hazards

- **When writing insurance on a minor, we need to know insurance in force on siblings and parents;** this information can be submitted in sections 19D, O, and 23 of the app.
- **Do not use correction tape.** Any corrections should be initialed by the proposed insured (or policy owner if the proposed insured is a minor).
- **If death benefit applied for is less than or equal to \$250,000:** no initial medical exams are required if the proposed insured is age 65 or younger. Ages 66 and up are fully underwritten and require initial exams.
- **For ANICO Signature Term™ applications only:** Form 4439 USA Patriot Act and Form 4528 Illustration Acknowledgement are not required
- **Agents must leave the MIB and FCRA Pre-notification with the client, page 10**
- **WHEN SUBMITTING APPS FOR LARGE FACE AMOUNTS, WE RECOMMEND A COVER LETTER TO EXPLAIN THE PURPOSE OF COVERAGE AND THE FINANCIALS ON THE FILE.**

Special Rider Instructions – Section 9 of the Application

- **When applying for ANICO Signature Term™ Rider on a Permanent Product:**
 - Select “Other” and complete the remainder of the fields to the right. See example below:

Type of Rider	Name of insured	Amount of insurance
<input type="checkbox"/> Other: Signature Term + [term of years]	Joe Client	\$ 100,000

- **If applying for more than one Signature Term Rider for multiple other insureds:**
 - You must complete Sections 2, 7, 12 for EACH proposed insured
 - Use an additional page 3 if you have more than 2 proposed insureds
 - Make sure the answers in Sections 13-18 clearly reference which proposed insured it applies to



Conditional Receipts

If the applied for Death Benefit is equal to or below \$500,000:

- Accepted Forms of Payment with the application: Cash, Check, PAC or Salary Deduction
- Conditional Receipt must be completed, signed and left with the client
- If the client completes a PAC or Salary Deduction form, indicate in the first blank on the Conditional Receipt, page 9, either "Payment Authorization form" or "Salary Deduction form"

If the applied for Death Benefit exceeds \$500,000:

- Do not provide a Conditional Receipt
- A PAC or Salary Deduction form may be submitted with the application. Please ensure the following:
 - If Electronic Fund Transfer is selected in Section 24(b), then in Section 25 the field entitled "Specify desired date or draft against account" must only be completed with "UPON ISSUANCE"
 - If the stand alone PAC Form 2011 is used instead of Section 25, in the fields entitled "Requested Withdrawal Date" and "Paid to Date" must only be completed with "UPON ISSUANCE"
 - If Salary Deduction is selected in Section 24(b), Form 971 Request for Deduction of Monthly Premiums from Salary may be completed but shall not be submitted to the employer until the policy is issued. Do not complete the field entitled "First Premium Due Date" until the policy is issued.
- NOTE: If Cash or Check is taken, it will be returned to the client



Application for Life Insurance

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One Moody Plaza, Galveston, TX 77550-7947



1. PRIMARY PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ b. Birthplace: City _____ State _____ Country _____

c. Date of birth: Month/Day/Year _____ d. Age last birthday _____ e. Height _____ f. Weight _____ g. Social Security/Tax ID number _____

h. Gender Male Female i. Marital status: Married Separated Single Widowed Divorced

j. Have you ever used tobacco or nicotine in any form? Yes No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | _____

k. Residence address: Number/Street _____ City _____ State _____ ZIP _____

l. Years at this residence _____ m. Personal telephone _____ n. Annual Income _____ Net worth _____
| (_____) _____ | \$ _____ | \$ _____

o. Type of business _____ Employer name _____ p. Business telephone _____
| _____ | (_____) _____

q. Occupation/Job title _____ Job duties (Be specific.) _____ r. Date of employment: Month/Year _____

s. Business address: Number/Street _____ City _____ State _____ ZIP _____

t. U.S. Citizen: Yes No If No, type of Visa _____ Expiration Date _____

2. ADDITIONAL PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ b. Birthplace: City _____ State _____ Country _____

c. Date of birth: Month/Day/Year _____ d. Age last birthday _____ e. Height _____ f. Weight _____ g. Social Security/Tax ID number _____

h. Gender Male Female i. Marital status: Married Separated Single Widowed Divorced

j. Have you ever used tobacco or nicotine in any form? Yes No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | _____

k. Residence address: Number/Street _____ City _____ State _____ ZIP _____

l. Years at this residence _____ m. Personal telephone _____ n. Annual Income _____ Net worth _____
| (_____) _____ | \$ _____ | \$ _____

o. Type of business _____ Employer name _____ p. Business telephone _____ q. Relationship to primary proposed insured _____
| _____ | (_____) _____ | _____

r. Occupation/Job title _____ Job duties (Be specific.) _____ s. Date of employment: Month/Year _____

t. Business address: Number/Street _____ City _____ State _____ ZIP _____

u. U.S. Citizen: Yes No If No, type of Visa _____ Expiration Date _____

3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name _____ First name _____ M.I. _____ b. Relationship to primary proposed insured _____

c. Gender Male Female d. Date of birth: Month/Day/Year _____ e. Age last birthday _____ f. Social Security/Tax ID number _____ g. If Trust, date created _____

h. Mailing address: Number/Street _____ City _____ State _____ ZIP _____

i. Contingent owner (If any): Last name _____ First name _____ M.I. _____ j. Relationship to primary proposed insured _____
| _____ | _____ | _____



4. SECONDARY OR ALTERNATE ADDRESSEE (Optional Secondary Addressee for notification of past due premiums):

Name | _____ Address: Number/Street | _____
City | _____ State | _____ ZIP | _____

5. CHILDREN PROPOSED FOR INSURANCE (COMPLETE FOR CHILDREN TERM RIDER)

Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Age	Ht./Wt.	Gender: M/F	Soc. Sec./Tax ID#
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

- a. Has the name of any child age 18 or younger been omitted? Yes (Explain.) | _____ No
- b. Is any child NOT living at the same address as the proposed insured? Yes (Explain.) | _____ No

6. BENEFICIARY FOR PRIMARY PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
Contingent: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

7. BENEFICIARY FOR ADDITIONAL PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to additional proposed insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

8. PRODUCT INFORMATION

a. Plan of insurance (Specify number of years if Term) _____ b. Amount of insurance _____

c. Premium amount \$ _____ Mode: Annual Semiannual Quarterly Monthly Single premium

d. If all proposed insured(s) are acceptable risks on a nonrated basis, but the premium quoted will not purchase the face amount requested:

- Do NOT change premium. Change face amount.
- Do NOT change face amount. Change premium.

Was automatic premium loan elected? Yes No (In Rhode Island, automatic premium loan is required, unless otherwise elected.)

If Participating Whole Life

e. Dividend option: Cash Premium reduction Paid-up additions Accumulate at interest

If Universal Life (including Indexed Universal Life and Variable Universal Life)

f. Death benefits options (Elect one - If no option is selected, Option "A" will be issued) Option A Option B Option C

If Indexed Universal Life

g. Initial Allocation of Net Premiums (Allocation must be designated in percentages and must total 100%)

_____ % Fixed Interest Crediting Option _____ % Indexed Interest Crediting Option

If Variable Universal Life

h. Guaranteed Coverage Period: (Elect one.) 10-year 25-year Other _____

Amount paid with application: \$ _____ (Check must be payable to American National Insurance Company.)



9. RIDERS/BENEFITS (Complete insurability application, if necessary.)

a. Optional benefits/riders:

- Premium waiver
- Waiver of stipulated premium \$ _____
- Accidental death \$ _____
- Children term \$ _____
- Spouse term \$ _____
- Guaranteed increase option \$ _____
- Additional insurance option \$ _____
- Return of Premium Rider
- Paid Up Additions Rider _____
Premium for PUA \$ _____
- Premium payor (Complete insurability application.)
- Coverage continuation rider
- Other insured rider (designate beneficiary below)
- Level term \$ _____

Other: Type of Rider _____ Name of insured _____ Amount of insurance \$ _____

Beneficiary for Other Insured Rider Coverage (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to other insured rider	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

10. INSURANCE AND REPLACEMENTS

- a. Do you have existing life insurance or annuity coverage? Yes No If yes, provide details below.
- b. Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company? Yes No
If "yes", indicate which one. **Agent must provide and complete the appropriate replacement form.**
- c. Total Insurance/Annuities in force on Proposed Insured(s): If none in force indicate "NONE".

Full Name of Company	Policy No.	Issue Date	Insured's Name	Plan	Amount	See "10b"
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Accidental Death \$ _____ Company _____

11. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents:

Is parent living (Y/N)	Age if living	Age at death	Cause of death
Father _____	_____	_____	_____
Mother _____	_____	_____	_____

Siblings:

Number of living	Number deceased	Age at death	Cause of death
_____	_____	_____	_____
_____	_____	_____	_____

- a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Yes No
Age at diagnosis | _____
- b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma? Yes No
Type | _____ Age at diagnosis | _____

12. ADDITIONAL PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents:

Is parent living (Y/N)	Age if living	Age at death	Cause of death
Father _____	_____	_____	_____
Mother _____	_____	_____	_____

Siblings:

Number of living	Number deceased	Age at death	Cause of death
_____	_____	_____	_____
_____	_____	_____	_____

- a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Yes No
Age at diagnosis | _____
- b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma? Yes No
Type | _____ Age at diagnosis | _____



13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC

a. Family physician, specialist or clinic of **proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
Address: Number/Street	City	State ZIP	Provider telephone number

b. Family physician, specialist or clinic of **additional proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
Address: Number/Street	City	State ZIP	Provider telephone number

14. MEDICAL HISTORY QUESTIONS—LIFETIME

(For questions "14.a." through "16.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 17.)

a. Is any proposed insured taking any medication(s)? Yes No (If "Yes," list medications and prescribed dosages).

HAS ANY PROPOSED INSURED EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR ...

- b. a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels?..... Yes No
- c. cancer, a tumor or abnormal growth of any kind? Yes No
- d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? Yes No

15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR ...

- a. seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system? Yes No
- b. asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system?..... Yes No
- c. any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis?..... Yes No
- d. any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine?..... Yes No
- e. diabetes or any disease of the thyroid or other gland? Yes No
- f. arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin?..... Yes No
- g. treatment or counseling for use of alcohol or alcoholism? Yes No
- h. treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? Yes No
- i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed?..... Yes No
- j. If any proposed insured(s) is less than one year old, give birth weight: | ____ lb. | ____ oz. Was birth premature? Yes No

16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS ...

- a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? Yes No
- b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test? Yes No
- c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed? Yes No



17. MEDICAL HISTORY EXPLANATIONS

(Give full details below of all "Yes" answers to questions "14.a." through "16.c.")

Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____
Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____
Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____
Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____

18. INSURANCE HISTORY AND NON-MEDICAL HAZARDS

- a. Has any proposed insured, in the past five (5) years, 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? Yes No (If "Yes," give details.)

- b. Has any proposed insured in the last six (6) months, applied for — or is any proposed insured contemplating applying for — other insurance with this, or any other, company? Yes No (If "Yes," state how much and to whom.)

- c. Has any proposed insured, in the past five (5) years, made — or is any proposed insured contemplating making — flights as a pilot, student pilot, crew member, or observer? Yes No (If "Yes," complete and submit the appropriate questionnaire.)
- d. Has any proposed insured, in the past five (5) years, engaged in or does any proposed insured intend to engage in mountain climbing, rock climbing, racing, SCUBA diving, hang-gliding, ballooning or skydiving? Yes No (If "Yes," complete and submit the appropriate questionnaire.)
- e. Has any proposed insured, in the past five (5) years, been convicted of a felony? Yes No (If "Yes," give details including county and state of conviction.)

- f. Is any proposed insured currently on parole or probation? Yes No (if "yes", give details.)

- g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?..... Yes No
- h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks?..... Yes No
(If "Yes," complete and submit the Foreign Travel Questionnaire.)

Primary Proposed Insured

- i. Driver's license number: | _____ State: | _____
- j. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?..... Yes No
(if "yes", give details.) | _____
- k. Do you have any other moving violations in the last five (5) years? Yes No
(if "yes", give details.) | _____

Additional Proposed Insured

- l. Driver's license number: | _____ State: | _____
- m. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?..... Yes No
(if "yes", give details.) | _____
- n. Do you have any other moving violations in the last five (5) years? Yes No
(if "yes", give details.) | _____



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declare for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true to the best of their knowledge and belief. They also agree that: (1) these answers as written: (i) were given to induce the company to issue a policy; and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial number as this application, no policy will be effective until it is: (i) issued; (ii) delivered to the applicant; and (iii) the full first premium paid, all during the lifetime and good health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be effective unless agreed to by the applicant in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and (5) only the president or 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: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

FRAUD STATEMENT

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

FCRA / MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

For Indexed Universal Life:

I understand that I am applying for an indexed universal life policy and that while the value of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investment.

For Variable Universal Life:

I understand that I am applying for a Variable Universal Life Policy. The accumulation value may increase or decrease depending on investment returns and the death benefit may be variable or fixed depending on the death benefit option selected.

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

Witnessed by: Signature of licensed agent	Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)
X _____	X _____

Print agent's name	Signature of additional person(s) proposed for insurance
_____	X _____

Agent's state license number	Signature of additional person(s) proposed for insurance
_____	X _____

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



19. SOLICITING AGENT'S REPORT: THESE QUESTIONS MUST BE ANSWERED IN EVERY CASE

- a. How long have you personally known the proposed insured? Years | _____ Months | _____
b. By whom will premiums be paid? [] Owner [] Applicant [] Other (If "Other," explain.) | _____
c. What is your estimate of the premium payor's annual income? \$ _____ and worth? \$ _____
d. If the proposed insured is a child, how much insurance does the Parent/Premium Payor have in force on his/her own life? \$ _____
e. Give any other surname(s) used by any proposed insured in the last five years. | _____
f. If beneficiary is not a relative, explain insurable interest. | _____
g. Did you see each person proposed for insurance when the application was completed? [] Yes [] No
h. Was beneficiary present during the completion of the application? [] Yes [] No
i. As agent, do you certify that, on the date of this application, you asked the proposed insured each question in the application, recorded the answers given you, witnessed such person's signature, and collected the initial premium shown in the application? [] Yes [] No
j. Do you have knowledge of any health history of any proposed insured not listed on this application? [] Yes [] No
k. As agent, did you determine this applicant's insurable objective and/or financial need? [] Yes [] No
l. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? [] Yes [] No
m. As agent, have you complied with state replacement regulations? [] Yes [] No
n. As agent, did you include individualized sales proposals in your presentations? [] Yes [] No
(If the primary proposed insured is replacing an existing plan(s) with this policy, the comparative information forms for each policy to be replaced, and copies of all sales material, MUST be included with this application sent to the home office.)
o. If a child, are there any other minor age siblings in the home? [] Yes [] No
If yes, do they have the same amount of coverage in force or applied for? [] Yes [] No If "no", explain _____

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 _____ Telephone number _____
X _____ | _____ | (_____) _____

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

If prior quote was reviewed, please provide quote number: | _____
Additional policy plan and amount
_____ \$ _____
Alternate policy plan and amount
_____ \$ _____
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 Form 6151.)
Agent name _____ Personal code or number _____ Agent name _____ Personal code or number _____
Special Instructions: | _____

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:
Oral fluid test collected by agent [] Yes [] No Date collected? | _____ [] Lab ticket attached or affix barcode here: _____
Inspection ordered [] Yes [] No (If "Yes," give name of inspection service used.)

[] Exam by physician, full blood, HOS [] EKG [] X-ray [] Paramed, full blood, HOS [] Full blood, physical measurements, HOS
[] Paramed, HOS | _____ [] Other | _____
Name of approved paramed company? | _____
Were medical records (APS) ordered by producer? [] Yes [] No (If "Yes," give physician/clinic name)

Did you pay for the attending physician's statement? [] Yes [] No
(If "Yes," enter check # | _____ and amount \$ _____)
Has the application been reviewed for omissions and errors? [] Yes [] No
If "yes", by (name) _____



22. NUMBER OF APPLICATIONS

Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National? Yes No
(If "Yes," give the serial number on the other application(s).)

23. NOTES TO UNDERWRITER

24. BILLING DATA

a. Mode: Annual Semiannual Quarterly Monthly Single premium

b. Method: Direct: (Fill in name and address where premium notices are to be sent, ONLY IF OTHER than those of primary proposed insured.)

Name _____

Number/Street _____ City _____

State ZIP _____ Country _____

Electronic fund transfer (EFT): (Complete "Electronic Fund Transfer" section 25 and attach a void check.)

MDO

Salary deduction: Name _____ Number _____

Biweekly Amount | _____

Government allotment: Payee name _____

A. Copy of certified allotment attached to application

B. Certified copy of Form 902 completed in lieu of allotment copy

C. Cash with application — No allotment copy

D. C.O.D. — Defer issue until allotment begins.

Rank | _____ Branch | _____ Social Security number | _____

Special dating instructions: Issue age | _____ Issue date | _____

25. ELECTRONIC FUND TRANSFER (EFT) INFORMATION: ATTACH "VOID" SPECIMEN OF CHECK

Name of premium payor who will pay premium _____ Social Security number _____

Name(s) of insured(s) _____

Account number: Checking Savings _____ Specify desired date for draft against account _____

Bank name _____ Branch name _____ 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 _____

Agent
X _____



CONDITIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

AMERICAN NATIONAL INSURANCE COMPANY
One Moody Plaza, Galveston, Texas 77550-7947

**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

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)

Signature of Owner

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

AMERICAN NATIONAL INSURANCE COMPANY
One Moody Plaza, Galveston, Texas 77550-7947

Thank you for considering American National Insurance Company as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

MIB Pre-notification — Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree, Suite 400, Braintree, MA 02184-8734.

The American National Insurance Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification — Federal and state laws require notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or, for the appropriate fee, receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.



AMERICAN NATIONAL INSURANCE COMPANY

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

A. Certification and Acknowledgment 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 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:

- 1. Gender Male Female Age _____
- 2. Underwriting or Rating Class _____ Type of Policy _____
- 3. Initial Death Benefit \$ _____ Dividend Option (if applicable) _____

AGENT DATE

B. Acknowledgment 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 DATE

AGENT DATE



Tax Advantage Form - Maryland

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

page 1 of 2

- American National Insurance Company (ANICO)
 American National Life Insurance Company of Texas (ANTEX)



UNIVERSAL LIFE

American National's Universal Life policy may or may not provide for significant tax advantages. For the specifics of any tax advantage provided by this policy, you should consult your tax consultant.

A copy of the above statement has been given to me. In addition, I request that American National provide me with an illustration of "guaranteed and current" values which extends beyond twenty (20) years. I understand that the projection of values is for illustrative purposes only and serves to provide a means for the comparison of similar products.

Date

Signature of Proposed Insured(s)

PROPOSED INSURED'S COPY



UNIVERSAL LIFE

American National's Universal Life policy may or may not provide for significant tax advantages. For the specifics of any tax advantage provided by this policy, you should consult your tax consultant.

A copy of the above statement has been given to me. In addition, I request that American National provide me with an illustration of "guaranteed and current" values which extends beyond twenty (20) years. I understand that the projection of values is for illustrative purposes only and serves to provide a means for the comparison of similar products.

Date

Signature of Proposed Insured(s)

SUBMIT TO HOME OFFICE WITH APPLICATION



Notice and Consent for Blood or Other Body Fluid Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

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

page 1 of 2

- American National Insurance Company (ANICO)
- American National Life Insurance Company of Texas (ANTEX)



EXAMINER _____

ADDRESS _____

To determine your insurability, the Insurer named above has requested that you provide sample(s) of your body fluids and/or tissues biological specimen for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), cotinine, cocaine, and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved in the underwriting and claim review process. If the HIV test is positive the results will be reported to the local health department or the State Department of Health and if the Insurer is a member of the Medical Information Bureau (MIB, Inc.), the Insurer may report the results in a generic code which signifies only non-specific test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.



Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS - related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely 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.

I have read and I understand this Notice of Consent for Blood or other body fluid testing which may include HIV Antibody/Antigen testing. I voluntarily consent to the collection of blood or other body fluid from me, the testing of that sample and the disclosure of the test results as described above.

In the event of a positive HIV test results, I authorize American National Insurance Company to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

(Physician's Name)

(Physician's Address)

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

Proposed Insured

Date of Birth

Signature of Proposed Insured
or Parent/Guardian

Date

State of Residence



Non-Qualified 1035 Exchange Request

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



Complete this form for Non-Qualified Accounts Only

1. FUNDS COMING FROM:

CHECK ONE:

NEW SALE, APPLICATION ATTACHED _____

ADDITIONAL DEPOSIT TO EXISTING POLICY NUMBER _____

TRANSFER COMPANY NAME AND ADDRESS: _____

TRANSFER COMPANY PHONE NUMBER: _____

NAME OF INSURED/ANNUITANT*: _____ SSN: _____

NAME OF OWNER: _____ SSN: _____

NAME OF JOINT OWNER: _____ SSN: _____

POLICY/ACCOUNT NUMBER WITH TRANSFER COMPANY: _____

JOINT ANNUITANTS ARE ONLY ACCEPTED ON SPIA's

2. TYPE OF TRANSACTION:

I/We direct the Institution named above to liquidate and transfer the assets to American National in order to set up a Non-Qualified account:

(MUST SPECIFY:)

Immediately Upon Maturity ____/____/____

1035 Exchange, Non-Qualified Policy **Non-1035 Exchange**, Non-Qualified Funds From:
Mutual Fund, Bank CD, or Other Non-Qualified Asset.

Full 1035 Exchange

The Assignor hereby designates American National Insurance Company as beneficiary of the above policy/contract.

Immediately following the above beneficiary designation, Assignor does hereby assign and transfer without exceptions, limitations or reservation to American National Insurance Company all assignable benefits, interest, property, rights, claims, options, privileges, obligations and title in the policy/contract in exchange for a new policy/contract as described in Assignor's application to American National Insurance Company for such policy/contract.

Assignor and American National Insurance Company expressly represent and recognize that the sole purpose of this assignment is to affect an exchange of insurance policies/contracts. Assignor represents and agrees that Assignor has consulted his/her own tax advisor regarding the tax consequences of this transaction. Assignor represents and agrees that American National Insurance Company has made no representations concerning Assignor's tax treatment under Internal Revenue Code Section 1035 or otherwise as a result of this transaction. American National Insurance Company assumes no responsibility or liability for the assignor's tax treatment under Internal Revenue Code Section 1035(a) or otherwise as a result of this transaction.

\$ _____

Partial 1035 Exchange

I understand the Internal Revenue Service may take the position that an exchange of a portion of an existing life insurance policy/contract for a new life insurance policy or an annuity contract, or the exchange of a portion of an existing life insurance or annuity contract for a new annuity contract, does not qualify as a valid exchange under Section 1035 of the Internal Revenue Code. I understand, acknowledge, and agree that American National assumes no liability or responsibility for any tax consequences associated with the proposed partial exchange.

\$ _____ _____ %

Please complete the information below if 1035 Exchange includes loan value:

\$ _____ Amount of 1035 Exchange \$ _____ Amount of loan included in 1035 Exchange
(Not available with all products)

Appropriate loan form must be submitted with the application if transferring loan value.



3. CONTRACT STATEMENT:

CONTRACT INCLUDED *If contract is not lost, please submit with this form.*

CERTIFICATE OF LOST CONTRACT

I/We certify that the above numbered contract has been lost or destroyed and to the best of my/our knowledge and belief, is not in anyone's possession.

4. SPECIAL INSTRUCTIONS:

5. SIGNATURES:

I/We agree that (1) American National is participating in this transaction at my specific request and as an accommodation to me; (2) American National and its representatives make no representation concerning treatment under IRC Section 1035(a) or otherwise; (3) American National assumes no responsibility nor any liability for the validity of this transaction or for the tax treatment under IRC Section 1035(a) and assumes that I/We consulted a tax advisor; (4) No person, firm, or corporation has a legal or equitable interest under the above referenced contract, except the undersigned, and no proceedings of either a legal or equitable nature have been instituted or are pending against the undersigned or involving the above referenced contract; and (5) the full-partial distribution from my existing contact may be subject to surrender charges.

I/We authorize the transaction described above.

For the benefit of: _____

Date at _____ this _____ day of _____, _____
(City, State)

Owner _____ Witness _____

Joint Owner _____ Witness _____

Annuitant _____

Agent _____

Guarantee (if required) _____

6. ACCEPTANCE: TO BE COMPLETED BY AMERICAN NATIONAL

The authorized signature below certifies acceptance of the assignment and surrender or transfer of funds as instructed in this request. After deducting any sums as are permitted under the plan, please complete this transaction and send a check with a copy of this form to:

ANNUITY SERVICES DEPARTMENT

American National Insurance Company
P.O. Box 10427
Springfield, MO 65808-0427
1-800-252-9546

If shipping via overnight service:

American National Insurance Company
Mail Processing Center
Attn: Annuity 10427
1949 E. Sunshine St.
Springfield, MO 65899-0001

VARIABLE CONTRACTS DEPARTMENT

American National Insurance Company
P.O. Box 9001
League City Tx 77594-9001
1-800-306-2959

If shipping via overnight service:

American National Insurance Company
Variable Contracts Dept.
2525 South Shore Blvd., Suite 300
League City Tx 77573-2989

LIFE NEW BUSINESS

American National Insurance Company
P.O. Box 3297
Springfield, MO 65808-3297
1-800-672-9960

If shipping via overnight service:

American National Family of Companies
Mail Processing Center
Attn: LNB 3297
1949 E. Sunshine St.
Springfield, MO 65899-0001

PLEASE MAKE CHECK PAYABLE TO: AMERICAN NATIONAL

By _____ Date _____
(Signature/Title)

FOR ALL 1035 EXCHANGES, PLEASE PROVIDE THE COST BASIS INFORMATION FOR THE CURRENT POLICY.



USA Patriot Act Notification and Customer Identification Verification

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



1. **Client Name** _____ **Application or Policy Number** _____

Source of Funds W-2 Wages Investments Social Security or Pension Savings another insurance contract
 Other (please explain) _____

USA PATRIOT Act Notice – to be read by or to customer.

2. The USA PATRIOT Act requires that we establish an Anti-Money Laundering (“AML”) Program, notify customers that we must verify the identity of the owner(s) of our contracts, and collect documents and information sufficient to provide such verification. You should know that failure to provide the requested identification will result in delays in the issuance of the requested coverage and may result in a decision not to accept your business.

Customer Identification Verification In order to satisfy such obligations, we require our representative to review and verify a current government issued photo ID for each Owner/Trustee/Partner associated with a contract. Information on such identification must be recorded below. We may use third party sources to verify the information provided.

a. **Identification Verified** (One for each Owner/Trustee/Partner. Use additional forms if necessary.)

Owner/Trustee/Partner

Joint Owner/Trustee/Partner

Check one form of ID:

Check one form of ID:

Driver’s license

Driver’s license

Resident Alien ID (Green Card)

Resident Alien ID (Green Card)

Passport

Passport

Other: (Describe) _____

Other: (Describe) _____

The following information should be recorded exactly as it appears on the identification reviewed

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Street Address (not PO Box) _____

Street Address (not PO Box) _____

City, State, Zip _____

City, State, Zip _____

Number on ID _____ State or Country _____

Number on ID _____ State or Country _____

Identification Expiration Date _____

Identification Expiration Date _____

b. **Entity Verification:** Check the appropriate entity as listed below and submit copies of documentation viewed to gain first-hand knowledge of the existence of a legitimate business. If the Owner is a minor or non-legal entity, review the identification of the individual who submits an application on behalf of the minor or non-legal entity.

Corporation, LLC, professional association, or professional corporation: Articles of Incorporation, Organization or Association or similar document filed in the state in which the entity is formed

Limited Partnership: Certificate of Limited Partnership or similar document filed in the state where the partnership is formed

General Partnership or Joint Venture: Agreement, Joint Venture Agreement or similar agreement governing the formation and operation of the partnership

Trust and All Other Entities: Document governing the formation and operation of the entity

3. I certify that I personally met with the proposed Owner(s)/Trustee(s)/Partners and reviewed the above identification document. To the best of my knowledge, it accurately reflects the identity of the proposed Owner(s)/Trustee(s)/Partners.

I was unable to personally review the identification documents for the reason stated below. I certify that, to the best of my knowledge, the information provided by the Owner(s)/Trustee(s)/Partners is true and accurate.

Reason for not reviewing documents _____

Note: Failure to personally review the identification documents will result in processing delays in order to verify customer identity and may result in a decision not to accept the business.

Representative Name _____ Personal Code _____

Representative Signature _____ Date _____



Life Insurance Buyer's Guide

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

page 1 of 4

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted By:





This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance also can be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.



How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up **cash values** and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.



Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY**. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.



Important Notice: Replacement of Life Insurance or Annuities

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

page 1 of 4

- American National Insurance Company (ANICO)
- American National Life Insurance Company of Texas (ANTEX)



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

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.

 Producer's Printed Name

 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.



Business Financial Questionnaire

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



I. Proposed Insured

- Name _____ File No. _____ DOB _____
- Occupation/Title _____
- Purpose of Coverage Key Person Buy/Sell Business loan or creditor insurance Executive Benefit Plan
 Other (please explain) _____
 - If this is for Buy/Sell coverage, is there a written agreement in force or being written? Yes No
 - If loan/creditor insurance, what is the amount of the loan? \$ _____
 - What is the purpose, origination date and duration of the loan? _____
- Has the business ever been reorganized due to financial problems? Yes No (if yes, please provide details including dates and resolution) _____

5. Proposed Insured's Compensation from this business:

	Most Recent Year	Previous Year
Source	_____	_____
Salary	_____	_____
Bonus	_____	_____
Commissions	_____	_____
Retained Earnings	_____	_____
Undistributed Profits	_____	_____
Stock Options	_____	_____
Other	_____	_____
Total	_____	_____

II. Business Information

- Name of Business _____ Type of Business _____
- Address of Business _____
- Other locations _____
- Date Business Started _____
- Company Web Address _____
- Proposed owner's % of ownership _____ Duration of ownership _____
Value of ownership _____
- Provide figures based on most recent complete business year:
Assets \$ _____ Gross Sales \$ _____
Liabilities \$ _____ Earnings before income tax, depreciation & amortization \$ _____
Net Worth \$ _____
Fiscal Year \$ _____

13. Complete the following for all partners, owners, and key executives

Name	Title	% of ownership	Business Insurance In force & /or Applied for	Purpose



14. If no other business associates are insured or expect to be insured for the benefit of the business, please explain reasons for only applying on the above proposed insured. _____

15. Fair Market Value for the Business \$ _____

16. How was Fair Market Value determined? _____

17. How was face amount applied for determined? _____

Fraud Warning

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.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured Signature _____ Date _____

Owner Signature _____ Date _____

Agent Signature _____ Date _____



Application - Additional Beneficiary Page for Life Insurance

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999



Provide corresponding application / policy number: _____ / Select the appropriate box for which this page applies.

Primary Proposed Insured Additional Proposed Insured Other Insured Rider _____

1. PRIMARY PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ Social Security/Tax ID number _____

b. Date of birth: Month/Day/Year _____ c. Residence address: Number/Street _____ d. City _____ e. State _____ f. ZIP _____

2. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name _____ First name _____ M.I. _____ Social Security/Tax ID number _____

b. Date of birth: Month/Day/Year _____ c. Residence address: Number/Street _____ d. City _____ e. State _____ f. ZIP _____

3. ADDITIONAL BENEFICIARY INFORMATION *(Unless specified, all beneficiaries in the same class share equally.)*

Primary: Last name	First name	M.I.	Relationship to proposed insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
Contingent: Last name	First name	M.I.	Relationship to proposed insured	Date of Birth: Mo./Day/Yr.	Gender	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

4. USE FOR ADDITIONAL BENEFICIARY DESIGNATIONS OR FOR SPECIAL BENEFICIARY SETTLEMENT OPTIONS:

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Date: Month/Day/Year _____ Signature of primary proposed insured (Or guardian, if proposed insured is under age 16) _____

_____ X _____

Witnessed by: Signature of licensed agent _____ Signature of additional person(s) proposed for insurance _____

X _____ X _____

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

_____ X _____

Agent's state license number / company personal code _____ Signature of owner if other than proposed insured _____

_____ X _____