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
☐ 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

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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

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Application for Life Insurance

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

* A P P *

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

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

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.)*

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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 $ _____

Type of Rider	Name of insured	Amount of insurance
☐ Other:		$

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 | _____

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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 ...

b. had 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. had 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) excluding HIV tests? ☐ Yes ☐ No

15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

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

a. had seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No

b. had asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system? ☐ Yes ☐ No

c. had any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis? ☐ Yes ☐ No

d. had any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? ☐ Yes ☐ No

e. had diabetes or any disease of the thyroid or other gland? ☐ Yes ☐ No

f. had 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. had treatment or counseling for use of alcohol or alcoholism? ☐ Yes ☐ No

h. had 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 excluding HIV tests? ☐ 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

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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

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 — any hazardous avocation or sport, such as SCUBA diving, parachuting, hang-gliding, vehicle racing, or other hazardous avocation(s)? ☐ 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.) | ______

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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

To the best of their knowledge or belief each of the undersigned declares 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. 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 if the answers to the questions remain as stated on the effective date, to the best of the applicants knowledge or belief 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

X _____

Print agent's name

_____

Agent's state license number

_____

Agent's company personal code

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

X _____

Signature of additional person(s) proposed for insurance

X _____

Signature of additional person(s) proposed for insurance

X _____

Signature of owner if other than proposed insured

X _____

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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) _____

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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 _____

AMERICAN NATIONAL

* C R C T *

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

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 _____

AMERICAN NATIONAL

* M I B *

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.

California - Life Comparison Statement

NF

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* I R F *

For Internal Replacements.

This form is required pursuant to California Insurance Code **§10509.3 (5) (B)** for all internal replacements. This form must be completed at the time of application and submitted to American National Insurance Company with the application. A copy of this form must be left with the applicant.

ANNUITANT INFORMATION

Name _____

Address _____

Telephone ( ) _____

Date of Birth _____

EXISTING POLICY VALUES

Please provide these policy/contract values for the current policy/contract immediately before the replacement:

Planned Premium _____

Minimum Premium (if applicable) _____

Premium Mode _____

Surrender Value, plus dividend, if any _____

Death Benefit _____

Outstanding Loan value _____

REPLACEMENT POLICY VALUES

Please provide these policy values for the proposed life policy as they would be immediately after the replacement:

Planned Premium _____

Minimum Premium (if applicable) _____

Premium Mode _____

Surrender Value, plus dividends, if any _____

Death Benefit _____

Outstanding Loan value _____

This comparison statement was completed in accordance with California Insurance Code **§10509.3 (5) (B)** and a copy was left with the applicant.

_____ _____

Producer's Signature Date

Summary and Disclosure Notice for Accelerated Benefits - Terminal Illness

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

* A B O *

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE TERMINAL ILLNESS RIDER. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY EACH RIDER.

Your policy contains an Accelerated Benefit Rider described in this summary and disclosure notice. The Rider is 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 an Accelerated Benefit and show proof that the Rider Insured has met the qualifying conditions of the Accelerated Benefit Rider, as described below.

There is no additional premium required for this Rider.

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.

No Accelerated Benefit will be paid under any Accelerated Benefit Rider for a condition that directly results from any intentional 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

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

This rider provides coverage for specified diseases as provided in this Rider. This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined by federal law.

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

This disclosure form is a summary only; the policy should be consulted to determine governing contractual provisions.

THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE CRITICAL ILLNESS RIDER. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE RIDER.

Your policy contains an Accelerated Benefit Riders described in this summary and disclosure notice. The rider is 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 Accelerated Benefit and show proof that the Rider Insured has met the qualifying conditions of the Accelerated Benefit Rider described below.

There is no additional premium required for this Rider.

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

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 supported by:

   1. associated new EKG changes which support the diagnosis; and,

   2. lab results that show elevated cardiac enzymes (proteins present in the blood) exceeding the 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. A stroke like event that is diagnosed as a transient ischemic attack, which is characterized by a temporary blockage that only lasts a short time and does not cause permanent damage, does not qualify as a Stroke.

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 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. early breast cancer.

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. **Amyotrophic Lateral Sclerosis (ALS) -** A diagnosis of ALS.

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.

i. **Arterial Aneurysms** – A localized widening (dilatation) of an artery, vein, or the heart.

j. **Central Nervous System Tumors** – Diagnosis of any abnormal solid growth involving the central nervous system (brain and/or spinal cord).

k. **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.

l. **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.

m. **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.

AMERICAN NATIONAL

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 directly results from any intentional 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.

The Rider may be reinstated pursuant to the Reinstatement provision in the Base Policy which the Rider is attached.

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

_____ _____

Owner Date

_____ _____

Agent Date

Notification to Elder Upon Buying Life Insurance or Annuity Products in California

NF

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* E L D E R A *

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this life insurance or annuity may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation, and that the elder may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

I, _____ hereby acknowledge that I have provided _____ with a copy of the Notification to Elder upon Buying Life Insurance or Annuity Products in California.

_____ _____
Agent's Signature **Date**

_____ _____
Owner Signature **Date**

Notice Regarding Standards for Medi-Cal Eligibility and Recovery

NF

For Distribution by Insurers, Agents, and Brokers

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* E L D E R *

State of California—Health and Human Services Agency

Department of Health Care Services

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $119,220 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $2,981 in monthly income, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $119,220 in countable resources. The order also may allow the at-home spouse to retain more than $2,981 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- One principal residence. One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

- *Real property used in a business or trade.* Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- IRAs, KEOGHs, and other work-related pension plans. These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- Personal property used in a trade or business.
- One motor vehicle.
- Irrevocable burial trusts or irrevocable prepaid burial contracts.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement.

To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

X Purchaser signature	Date
X Spouse's signature	Date
X Legal representative signature	Date

American National Insurance Company
American National Life Insurance Company of Texas
Garden State Life Insurance Company
Standard Life and Accident Insurance Company

IMPORTANT NOTICE OF PRIVACY POLICY And INFORMATION PRACTICES

The American National Companies respect your right to privacy. This notice explains how we collect and use personal data about our customers.

Information We Collect

The personal data about you we obtain may include:

- Name, age, addresses, social security number, marital status
- Occupation, current and past medical history, financial information

We collect personal data from a variety of sources, such as:

- Applications or other forms you submit
- Consumer reporting agencies and insurance data banks
- Your business dealings with us or other companies

How We Use and Disclose Personal Data

We do not share or sell personal data about our current or former customers to anyone. We only disclose data about you as permitted or required by law. Where permitted by law, such disclosures may be made without further notice to you.

Disclosures we may legally make include:

- Those necessary to service your insurance or annuity contract
- Those made with your approval or at your direction
- Those made to assist law enforcement and prevent fraud
- Those made to comply with federal, state or local laws

We protect your personal data. The only employees who have access to your data are those who must have it to provide products or services to you.

Examples of functions that require access to personal data include:

- Underwriting and policy service
- Claims processing
- Reinsurance

We share personal data with insurance data banks that collect information about claim history. Insurance data banks may retain personal data and disclose it to other insurance companies and others legally entitled to see it.

We send current customers a privacy notice each year. If we change our practices, we will inform you promptly.

Your Right To Review and Correct Personal Data

You have the right to review your personal data in our files, and to ask us to correct data if it is in error. You have the right to ask us to delete data you do not wish us to keep. We will only continue to keep that data if it is required in order to service your insurance.

If you wish to review your personal data, please send a written request to **Privacy Compliance, P. O. Box 1896, Galveston, Texas 77553-9902.** Include your name, address, telephone number, policy number and Company name.

Important Notice to Applicant Replacing American National Life Insurance

F

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* I R F *

REPLACEMENT is any transaction where, in connection with the purchase of new life insurance, you lapse, surrender, place on extended term, or borrow all or part of the policy loan values on an existing insurance policy.

If you intend to replace your present life insurance, you should consider the following before making a final decision:

1. It may be to your advantage to obtain information regarding your existing policy or policies from the agent from whom you purchased the policy so that a comparison can be made of the two products.
2. You may be required to provide **EVIDENCE OF INSURABILITY** for the new policy for any additional coverage requested, and
   a. If your **HEALTH HAS CHANGED** since the application was taken on your present policy, you may be required to pay **ADDITIONAL PREMIUMS** under the **NEW POLICY**, or be **DENIED** coverage.
   b. Your present occupation or activities may not be covered or may require additional premiums.
   c. The **INCONTESTABLE** and **SUICIDE CLAUSES** could begin anew in a new policy. This could result in a **CLAIM** under the new policy **BEING DENIED** that would otherwise have been paid.
3. You may incur **HIGHER COSTS** on certain policy features such as a **HIGHER INTEREST RATE** on **POLICY LOANS** and new **SURRENDER CHARGES** on a new policy.
4. If you change your mind, you will be required to furnish evidence of insurability to reinstate a lapsed or surrendered life insurance policy. Therefore, you should not take action to terminate or alter your existing policy until after you have carefully considered your options and insurance needs.

THE INSURANCE I INTEND TO PURCHASE MAY REPLACE OR ALTER THE FOLLOWING EXISTING LIFE INSURANCE POLICY OR POLICIES:

POLICY NUMBER	FACE AMOUNT
_____	_____
_____	_____

The proposed new policy is: _____ _____
Type of Policy - Generic Name | Face Amount

I have read the "IMPORTANT NOTICE TO APPLICANT REPLACING LIFE INSURANCE" furnished to me by the agent taking my application for this policy.

Signature of Applicant | Date | Agent's Signature | Date

Address

City | State | ZIP Code

Notice Regarding Replacement

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)

* I R F *

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

_____ _____

(Applicant's Signature) (Date)

_____ _____

(Agent's Signature) (Date)

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

F

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* H I V *

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:

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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

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

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* H I V *

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

Notice of Senior In-Home Insurance Presentation
Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

* E L D E R *

THIS NOTICE MUST BE DELIVERED NO LESS THAN 24 HOURS AND NO MORE THAN 14 DAYS PRIOR TO THE INITIAL MEETING.

Agent's Full Name:

_____

(As it appears on California insurance license)

Agent's License Number: _____

Agent's Mailing Address and Telephone Number (as listed on California insurance license):

_____

_____

1. **I am a licensed insurance agent. My purpose for coming to your home on _____ is to sell, discuss, and/or deliver one of the following *(check all that apply)*:**
   - ☐ **Life insurance, including annuities.**
   - ☐ **Other insurance products *(specify)*:**
2. **You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.**
3. **You have the right to end the meeting at any time.**
4. **You have the right to contact the Department of Insurance for information, or to file a complaint. The CA Department of Insurance consumer assistance telephone number is 800-927-HELP (4357).**
5. **The following individuals will be coming to your home:**

Name	***Insurance License Number***
_____	_____
_____	_____

_____

(Print name)

_____ _____

(Signature) ***Date***

Supplement Application for Accelerated Benefit Riders (Critical)

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

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CRABRSUP

Proposed Insured's Name | Date of Birth | Policy Number

GENERAL DETAILS OF OTHER COVERAGE AND REPLACEMENTS

1. Is the applicant currently covered by comprehensive health benefits from an individual or group health policy or an HMO or employer plan providing essential health benefits? ❑ Yes ❑ No
   NOTICE: An applicant that is not covered by comprehensive health coverage is not eligible for this product.

MEDICAL QUESTIONS

Has a member of the medical profession ever diagnosed the Proposed Insured with or treated the Proposed Insured For:

1. Memory Loss?	❑ Yes	❑ No	15. Multiple Myeloma?	❑ Yes	❑ No
2. Paralysis?	❑ Yes	❑ No	16. Amputation due to disease?	❑ Yes	❑ No
3. Stroke?	❑ Yes	❑ No	17. Heart Disease or Disorder?	❑ Yes	❑ No
4. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	❑ Yes	❑ No	18. Liver Disease?	❑ Yes	❑ No
			19. Diabetes?	❑ Yes	❑ No
5. Parkinson's Disease?	❑ Yes	❑ No	20. Connective Tissue Disorder?	❑ Yes	❑ No
6. Multiple Sclerosis?	❑ Yes	❑ No	21. Joint Replacement?	❑ Yes	❑ No
7. Muscular Dystrophy?	❑ Yes	❑ No	22. Back Surgery?	❑ Yes	❑ No
8. Myasthenia Gravis?	❑ Yes	❑ No	23. Cancer (excluding Basal Cell Skin Cancer)	❑ Yes	❑ No
9. Huntington's Chorea?	❑ Yes	❑ No	24. Organ Transplant?	❑ Yes	❑ No
10. Emphysema?	❑ Yes	❑ No	25. Substance Abuse?	❑ Yes	❑ No
11. Chronic Obstructive Pulmonary Disease?	❑ Yes	❑ No	26. Hypertension (Systolic BP > 200 and/or Diastolic BP > 110)	❑ Yes	❑ No
12. Chronic pain currently requiring treatment with narcotic medication or medicinal marijuana?	❑ Yes	❑ No	27. Disease of the eye other than that corrected solely by glasses or contacts?	❑ Yes	❑ No
13. Kidney Disease?	❑ Yes	❑ No			
14. Cystic Fibrosis?	❑ Yes	❑ No	28. Aneurysms or other diseases of the arteries?	❑ Yes	❑ No

NOTICE

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

DECLARATION OF AGREEMENT AND SIGNATURES

I understand that AMERICAN NATIONAL INSURANCE COMPANY may use other medical information that it obtains about me that I have authorized them to obtain for medical underwriting purposes. That information may be from a 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, or a paramedical facility.

I understand and agree that all answers given above are to the best of my knowledge and belief complete and true. This application shall be part of any contract issued.

Applicant *(Sign name in full)* _____ Date _____

Proposed Insured *(If other than the Applicant, sign name in full)* _____ Date _____

Agent *(Sign name in full)* _____ Date _____

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:

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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.

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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.