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

AMERICAN NATIONAL

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

AMERICAN NATIONAL

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

AMERICAN NATIONAL

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.)*

AMERICAN NATIONAL

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

a. Optional benefits/riders:

☐ Disability Premium Waiver
☐ Waiver of stipulated premium $ _____
☐ Accidental death $ _____
☐ Children term $ _____
☐ Spouse term $ _____
☐ Guaranteed increase option $ _____
☐ Additional insurance option $ _____
☐ Additional Protection Benefit Rider $ _____
☐ 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 $ _____

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

To the best of my knowledge and belief:

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

To the best of my knowledge and belief:

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 | _____

AMERICAN NATIONAL

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...

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 tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS cause by the HIV infection or other sickness or condition derived from such infection? ☐ 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. 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, or narcotics 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. been diagnosed or treatment by a licensed member of the medical professional to have 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

AMERICAN NATIONAL

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 within the next two (2) years 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 within the next two (2) years 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 in the next two (2) years intend to engage in mountain climbing, rock climbing, SCUBA diving, parachuting, hang gliding, racing, 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

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.) |

AMERICAN NATIONAL

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 my knowledge and 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 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 injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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:
The benefits, values, or premiums are on a variable basis, may increase or decrease, and are not guaranteed as to fixed dollar amount.

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 _____

AMERICAN NATIONAL

* A G R *

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) _____

AMERICAN NATIONAL

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 Agent's state license number

X _____ **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 _____

Agent's state license number

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.

Summary and Disclosure Notice for Accelerated Benefits - Florida

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

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

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

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

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

There is no additional premium required for these Riders.

An administrative fee of $100, 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 12 months or less.

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

a. is unable to perform at least two (2) Activities of Daily Living, without Substantial Assistance from another person, due to a loss of functional capacity for a period of at least ninety (90) days; or,

b. requires supervision by another person to protect the Rider Insured from threats to health and safety due to the Rider Insured's Severe Cognitive Impairment.

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

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

a. comparable to, and includes, Alzheimer's Disease and similar forms of irreversible dementia; and,

b. measured by clinical evidence and standardized tests which reliably measure impairment in: short term or long term memory; orientation to people, places, or time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

No Accelerated Benefit will be paid for a Covered Chronic Illness diagnosed or certified on or before the date of issue of the Base Policy or Covered Rider(s) to which this Rider is attached.

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

a. **Heart Attack** (myocardial infarction) – The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart Attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. The diagnosis of a Heart Attack must be made by a Physician board certified in Cardiology and based on the presence of:

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

   2. elevation of cardiac enzymes above standard laboratory levels.

b. **Stroke** – A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis resulting in paralysis or other measurable neurological deficit which persists for 96 hours following the occurrence of the Stroke. Stroke does not include transient ischemic attacks. The diagnosis of a Stroke must be made by a Physician board certified in Neurology.

c. **Invasive Cancer** – A disease which is characterized by the presence and uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Invasive Cancer must be diagnosed by a pathological or clinical diagnosis. Invasive Cancer does not include:

   1. any skin cancer, except invasive malignant melanoma into the dermis or deeper;
   2. pre malignant lesions, benign tumors, or polyps;
   3. early prostate cancer diagnosed as T1N0M0 or equivalent staging; or,
   4. carcinoma in situ.

d. **Diagnosis of End Stage Renal Failure** – The irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.

e. **Major Organ Transplant** – The receipt by transplant of any of the following organs or tissues; heart, lung, liver, kidney, pancreas, small intestine or bone marrow. The Rider Insured must be registered on the United Network of Organ Sharing.

f. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis)** by a qualified Physician.

g. **Blindness** – The total and permanent loss of sight in both eyes as a result of disease or injury and results in a reduced life expectancy. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.

h. **Paralysis** – The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days. Paralysis must be confirmed by a Physician board certified in Neurology.

i. **Arterial Aneurysms** – A localized widening (dilatation) of an artery, vein, or the heart. The diagnosis of an Arterial Aneurysm must be made by a Physician board certified in Cardiology.

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

k. **Major Multi System Trauma** – Any major accident or injury resulting in significant alteration of any three (3) body systems which requires hospitalization and extended rehabilitation, results in permanent impairment of the function and/or altered ability to perform Activities of Daily Living, and significantly alters the Rider Insured's life expectancy.

l. **Auto Immune Deficiency Syndrome (AIDS)** – Advanced HIV infection that is associated with an AIDS defining condition (P. carinii pneumonia, esophageal candidiasis, wasting, Kaposi's sarcoma, disseminated mycobacterium avium infection, tuberculosis, cytomegalovirus disease, HIV associated dementia, recurrent bacterial pneumonia, toxoplasmosis, immunoblastic lymphoma, chronic cryptosporidiosis, Burkitt lymphoma, disseminated histoplasmosis, invasive cervical cancer and chronic herpes simplex) and has been diagnosed by a Physician.

m. **Severe Disease of Any Organ** – Severe Disease of Any Organ system is any illness that is life threatening, requires inpatient hospital care and, and will significantly alter the Rider Insured's life expectancy, as diagnosed by a Physician.

n. **Severe Central Nervous System Disease** – Severe disease of the central nervous system, brain and/or spinal cord, as diagnosed by a Physician that is life threatening and significantly alters the Rider Insured's life expectancy, as diagnosed by a Physician. Severe Central Nervous System Disease includes, but is not limited to, progressive multiple sclerosis, Parkinson's Disease, Huntington's chorea and encephalitis which permanently alters a portion of the cerebrum.

o. **Major Burns** – The diagnosis by a Physician board certified in plastic surgery, that the Rider Insured has sustained third degree burns covering at least 40% of the surface area of the Rider Insured's body.

p. **Loss of Limbs** – The complete and permanent severance of two or more limbs through or above the elbow or knee joint due to trauma or accident and results in a reduced life expectancy. Loss of Limbs as a result of disease process is excluded from this definition.

No Accelerated Benefit will be paid for any Qualifying Event that occurs on or before the date of issue of the Base Policy or Covered Rider(s) which this Rider is attached.

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

The Accelerated Benefit will be paid to you in lieu of all or a portion of the Eligible Death Benefit. The Eligible Death Benefit is the total amount of death benefit available for acceleration under the base policy and any Covered Riders. The Accelerated Benefit Payment will be equal to the Eligible Death Benefit less the actuarial discount, as determined by Us; an administrative charge of $100 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

_____ _____

Licensed Agent / Insurance Producer Date

_____

Florida Licensed Identification Number

Replacement Notice

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

F

FL D14-1180 (9/95)

PLEASE READ CAREFULLY. This information has been prepared for you so that you may make an informed decision on the use of any of your policy values to fund the purchase of a new policy. Please see the reverse side of this form for explanatory notes and instructions as to how this form has been completed.

PART A - CURRENT POLICY INFORMATION ☐ **LIFE** ☐ **ANNUITY**

Policyowner's Name: _____ Policy Number: _____

Current Death Benefit: $ _____ Current Premium Amount: $ _____ Mode of Payment: _____

Cash Surrender Value: $ _____ Paid-up Addition Value: $ _____ Dividend Value: $ _____
(The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the policy proposed in Part B, below)

PART B - PROPOSED POLICY INFORMATION ☐ **LIFE** ☐ **ANNUITY**

Initial Death Benefit: $ _____ Proposed Premium Amount: $ _____ Mode of Payment _____

Proposed Effective Date: _____ Premium Payable to Age _____ or for _____ Years

NOTE: If you are replacing your current policy, or using 25% or more of your policy values, you may request a WRITTEN comparison between your current policy and the proposed policy. The comparison is to illustrate the policy values for both policies.

PART C - SOURCE OF FUNDING FOR THE PROPOSED POLICY

A loan in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode), bearing a current loan interest rate of _____ %.

A partial surrender in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode).

A dividend withdrawal in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode).

PART D - YOUR CURRENT POLICY COULD TERMINATE

If the policy values of your CURRENT POLICY are used as a source of funding for the purchase of an additional policy, it is estimated that your CURRENT POLICY will terminate on _____ (date).

It is estimated that you will begin making premium payments for the PROPOSED POLICY from your own funds on _____ (date) in the amount of $ _____ to be paid each _____ (mode).

NOTE: Since the values and premiums stated on this form may change over time, the estimated date upon which you will need to begin making premium payments from your own funds for the PROPOSED POLICY may also change. Estimates as to dates when policies will terminate or payments must begin assume the continuation of current (or guaranteed) factors, and such calculations are based upon the assumption that any premiums or interest due on loans are paid when due.

Policyowner Signature: _____ Date: _____

Agent or Company Officer Signature: _____ Date: _____

Florida Licensed Agent ID No. or Corporate Title: _____

(See reverse side for instructions.)

AMERICAN NATIONAL

POLICY DISCLOSURE FORM AND INSTRUCTIONS
COMPLETE ONE FORM FOR EACH PREVIOUSLY ISSUED POLICY
ANY REQUIRED REPLACEMENT AND SALES FORMS MUST ALSO BE COMPLETED
ONE COPY IS DELIVERED TO THE POLICYOWNER AND ONE COPY MAINTAINED BY THE INSURER

Any and all information applicable to the transaction shall be fully and completely disclosed on Form D14-1180. If the information requested does not apply to the transaction, the words "not applicable" or "N/A" shall be entered.

PART A

The information to be disclosed in Part A of Form D14-1180 shall apply to the current, in-force policy for which policy values are being utilized as a source of funding for the purchase of additional insurance contract(s). For purposes of this form, "current death benefit" is defined as the sum of the death benefit payable under the base policy, all life insurance riders covering the principal insured (other than special contingency death riders), paid-up additional insurance and dividends, minus outstanding indebtedness. The term "cash surrender value" is defined as the cash value of the policy or contract net of any outstanding indebtedness and surrender charges, and less any dividend value. The term "paid-up addition value" is defined as the cash value of additional insurance purchased with policy dividends. The term "dividend value" is defined as the total cash value of all policy dividends left on deposit with the company to accumulate at interest.

PART B

The information to be disclosed in Part B of Form D14-1180 shall apply to the proposed additional insurance contract(s) being funded by policy values in a current, in-force policy. For purposes of this form, "proposed premium amount" is defined as any recurring payment which is planned to be paid or which is required to be paid under the proposed policy.

PART C

The information to be disclosed in Part C of Form D14-1180 shall apply to the current, in-force policy, and shall indicate the manner in which the policy values are being used to fund the purchase of the proposed policy. Part C is **not** to be completed if the current policy is totally surrendered. However, in the event of a total surrender of the current policy, Parts A, B, D, and the signature block of this form must still be completed.

When completing Part C of this form, each and every source of funding for the proposed policy must be identified, i.e., whether a policy loan, partial surrender, or dividend withdrawal or any combination thereof is being utilized. If more than one source of funding will be utilized to fund the initial and/or future premiums for the proposed policy, all applicable sections of Part C shall be completed.

For purposes of this form, a "partial surrender" is defined as any amount taken from the value of the current policy which is less than the total cash value available under such policy. The term "mode" is defined as the frequency upon which a policy loan, partial surrender or dividend withdrawal will be taken from the value of the current policy. In the event of a single loan, surrender or withdrawal, the words "one time only" shall be entered in the space provided. The term "loan interest rate" is defined as the rate of interest in effect on the date that this form is completed, as specified in the current policy contract.

PART D

The information to be disclosed in Part D of Form D14-1180 shall apply to the current, in-force policy and the proposed additional policy, respectively.

SIGNATURES

In order to evidence that the required disclosure has been made, Form D14-1180 shall be signed and dated by the soliciting agent or by a Corporate Officer, as well as by the policyowner. For identification purposes, the agent or Corporate Officer shall enter his or her Florida License Number or Corporate title, respectively, in the space provided.

Notice to Applicant Regarding Replacement of Life Insurance or Annuities

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 *

A decision to buy a new contract and discontinue or change an existing contract may be a wise choice or mistake.

Get all the facts. Make sure you fully understand both the proposed contract and your existing contract or contracts. New contracts may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as suicide and incontestable clauses which may have already been satisfied in your existing contract or contracts.

Your best source for facts on the proposed contract is the proposed company and its agent. The best source of your existing contract is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing contract, Florida regulations require notification of the company that issued the contract.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your contract values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

Yes	No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING CONTRACT UNTIL YOUR NEW CONTRACT HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

Applicant's Signature	Date
Agent's Signature	Date

Agent's Name (Printed Or Typed)

Agent's Address (Printed Or Typed)

Agent's Company (Printed Or Typed)

Information on Contracts which may be replaced:

Company Name	Policy Number	Name of Insured

Comparative Information Form for Proposed Insurance

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 *

_____
(Proposed Insurer)

_____
(Insurer's Address)

_____
(Replacing Agent's Name)

Applicant Information

Name _____

Address _____

Telephone (_____) _____

Date of Birth _____ Age _____

Policy Information

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Clause _____

Policy Loan Rate _____

Policy/Rider Description

Policy/ Rider Name	Initial/ Continuing Benefit	(Age) Benefit From	To	Initial/ Renewal Annual Premium	(Age) Payable From	To

TOTAL INITIAL ANNUAL PREMIUM $_____ MODE OF PAYMT. _____ AMT. $_____

TOTAL INITIAL RENEWAL PREMIUM $_____ AMT. $_____

AMERICAN NATIONAL

COMPOSITE DISCLOSURE OF EXISTING INSURANCE FOR PRIMARY INSURED

		Guarantees				Projections*			
Yr	Age	Annual Premium	Cumlty Premium	Cash Value	Death Benefit	Annual Premium	Cumlty Premium	Cash Value	Death Benefit
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
	55								
	60								
	65								
	75								
	85								
	95								

*Projections include dividends and current interest rates which are not guaranteed.

Important Notice:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude.

Competent tax advice should be secured to clarify income tax implications.

NOTICE AND CONSENT FORM FOR BLOOD, ORAL FLUID, AND/OR URINE SPECIMEN TESTING TO DETERMINE THE PROBABLE CAUSATIVE AGENT FOR AIDS

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 *

To evaluate your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that the underwriting decisions will be based on the result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related blood 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 A POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and 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 increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. 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 adversely affect your application for insurance.

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 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 test 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.

NOTIFICATION OF TEST RESULTS

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test results mean, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: _____

Address _____

CONSENT

I have read and understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

X _____

Signature of Proposed Insured or Parent/Guardian Date Signed

_____

Name and Address of Proposed Insured (Please Print)