



**1. PRIMARY PROPOSED INSURED**

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

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

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

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

k. Residence address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

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

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

s. Business address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

**2. ADDITIONAL PROPOSED INSURED**

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

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

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

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

k. Residence address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

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

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

t. Business address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

**3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)**

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

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

h. Mailing address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

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



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

Name | \_\_\_\_\_ Address: Number/Street | \_\_\_\_\_  
City | \_\_\_\_\_ State | \_\_\_\_\_ ZIP | \_\_\_\_\_

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

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

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

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

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

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

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

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

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

**8. PRODUCT INFORMATION**

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

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

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

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

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

**If Participating Whole Life**

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

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

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

**If Indexed Universal Life**

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

\_\_\_\_\_ % Fixed Interest Crediting Option \_\_\_\_\_ % Indexed Interest Crediting Option

**If Variable Universal Life**

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

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



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

a. Optional benefits/riders:

- Optional benefits/riders including Premium waiver, Return of Premium Rider, Waiver of stipulated premium, Paid Up Additions Rider, Accidental death, Premium for PUA, Children term, Premium payor, Spouse term, Coverage continuation rider, Guaranteed increase option, Other insured rider, Additional insurance option, 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.)

Table with columns: 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?
b. Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company?
c. Total Insurance/Annuities in force on Proposed Insured(s): If none in force indicate "NONE".

Table with columns: 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?
b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?

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?
b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?



**13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC**

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

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

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

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

**14. MEDICAL HISTORY QUESTIONS—LIFETIME**

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

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

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

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

**15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS**

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

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

**16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS**

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

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



**17. MEDICAL HISTORY EXPLANATIONS**

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

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

**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?
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?
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?
d. Has any proposed insured, in the past five (5) years, engaged in or does any proposed insured intend to engage in mountain climbing, rock climbing, racing, SCUBA diving, hang-gliding, ballooning or skydiving?
e. Has any proposed insured, in the past five (5) years, been convicted of a felony?
f. Is any proposed insured currently on parole or probation?
g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?
h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks?

**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?
k. Do you have any other moving violations in the last five (5) years?

**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?
n. Do you have any other moving violations in the last five (5) years?



**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

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

I understand that:

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

**APPLICATION DECLARATIONS AND AGREEMENTS**

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

**FRAUD STATEMENT**

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

**FCRA / MIB ACKNOWLEDGEMENT**

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

**APPLICATION SIGNATURES**

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

**For Indexed Universal Life:**

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

**For Variable Universal Life:**

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

Date: Month/Day/Year                      Signed at: City                      State                      Country  
 \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

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

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

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

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



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

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

Dated at: City \_\_\_\_\_ Month/Day/Year \_\_\_\_\_
Corporation name \_\_\_\_\_ Tax ID \_\_\_\_\_ Social Security number \_\_\_\_\_
Branch office number and PSO code \_\_\_\_\_ Agent personal code or number \_\_\_\_\_ CSSD District Code 2 \_\_\_\_\_ Agency # \_\_\_\_\_
Licensed agent's signature \_\_\_\_\_ Agent e-mail \_\_\_\_\_ Telephone number \_\_\_\_\_
X \_\_\_\_\_ | \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

If prior quote was reviewed, please provide quote number: | \_\_\_\_\_
Additional policy plan and amount
\_\_\_\_\_ \$ \_\_\_\_\_
Alternate policy plan and amount
\_\_\_\_\_ \$ \_\_\_\_\_
Are commissions to be split? [ ] Yes [ ] No (If "Yes," and split 50/50, list both agents' names and personal code number. If NOT, complete and submit Form 6151.)
Agent name \_\_\_\_\_ Personal code or number \_\_\_\_\_ Agent name \_\_\_\_\_ Personal code or number \_\_\_\_\_
Special Instructions: | \_\_\_\_\_

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:
Oral fluid test collected by agent [ ] Yes [ ] No Date collected? | \_\_\_\_\_ [ ] Lab ticket attached or affix barcode here: \_\_\_\_\_
Inspection ordered [ ] Yes [ ] No (If "Yes," give name of inspection service used.)
\_\_\_\_\_
[ ] Exam by physician, full blood, HOS [ ] EKG [ ] X-ray [ ] Paramed, full blood, HOS [ ] Full blood, physical measurements, HOS
[ ] Paramed, HOS | \_\_\_\_\_ [ ] Other | \_\_\_\_\_
Name of approved paramed company? | \_\_\_\_\_
Were medical records (APS) ordered by producer? [ ] Yes [ ] No (If "Yes," give physician/clinic name)
\_\_\_\_\_
Did you pay for the attending physician's statement? ..... [ ] Yes [ ] No
(If "Yes," enter check # | \_\_\_\_\_ and amount \$ \_\_\_\_\_)
Has the application been reviewed for omissions and errors? ..... [ ] Yes [ ] No
If "yes", by (name) \_\_\_\_\_



**22. NUMBER OF APPLICATIONS**

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

**23. NOTES TO UNDERWRITER**

**24. BILLING DATA**

a. Mode:  Annual  Semiannual  Quarterly  Monthly  Single premium

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

Name  
|\_\_\_\_\_

Number/Street \_\_\_\_\_ City \_\_\_\_\_

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

State ZIP \_\_\_\_\_ Country \_\_\_\_\_

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

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

MDO

Salary deduction: Name \_\_\_\_\_ Number \_\_\_\_\_

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

Biweekly Amount |\_\_\_\_\_

Government allotment: Payee name \_\_\_\_\_

|\_\_\_\_\_

A. Copy of certified allotment attached to application

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

C. Cash with application – No allotment copy

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

Rank |\_\_\_\_\_ Branch |\_\_\_\_\_ Social Security number |\_\_\_\_\_

Special dating instructions: Issue age |\_\_\_\_\_ Issue date |\_\_\_\_\_

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

Name of premium payor who will pay premium \_\_\_\_\_ Social Security number \_\_\_\_\_

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

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

Bank name \_\_\_\_\_ Branch name \_\_\_\_\_ Bank transit number \_\_\_\_\_

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

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

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

Date: Month/Day/Year \_\_\_\_\_ Signature of premium payer \_\_\_\_\_

Agent \_\_\_\_\_ X \_\_\_\_\_





**CONDITIONAL RECEIPT**

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

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

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

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

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

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

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

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

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

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

Signature of licensed agent

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 \_\_\_\_\_

**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, Inc. 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc. 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, Inc. may be obtained on its website at [www.mib.com](http://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

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

page 1 of 3



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

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

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

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

There is no additional premium required for these Riders.

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

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

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

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

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

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

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

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

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



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

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

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

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

\_\_\_\_\_

Owner

\_\_\_\_\_

Date

\_\_\_\_\_

Agent

\_\_\_\_\_

Date



# Important Notice

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

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



**DEFINITION: REPLACEMENT IS** any transaction where, in connection with the purchase of New Insurance or a New Annuity, you **LAPSE, SURRENDER, CONVERT** to Paid-up Insurance, Place on Extended Term, or **BORROW** all or part of the policy loan values on an existing insurance policy or an annuity. (See reverse side for **DEFINITIONS.**)

**IF YOU INTEND TO REPLACE COVERAGE:** In connection with the purchase of this insurance or annuity, if you have **REPLACED** or intend to **REPLACE** your present life insurance coverage or annuity(ies), you should be certain that you understand all the relevant factors involved. You should **BE AWARE** that you may be required to provide **EVIDENCE OF INSURABILITY** and

1. IF your **HEALTH** condition has **CHANGED** since the application was taken on your present policies, you may be required to pay **ADDITIONAL PREMIUMS** under the **NEW POLICY**, or be **DENIED** coverage.
2. Your present occupation or activities may not be covered or could require additional premiums.
3. The **INCONTESTABLE** and **SUICIDE CLAUSE** will begin anew in a new policy. This could **RESULT** in a claim under the new policy **BEING DENIED** that would otherwise have been paid.
4. Current law **MAY NOT REQUIRE** your present insurer(s) to **REFUND** any premiums
5. It is to your advantage to **OBTAIN INFORMATION** regarding your existing policies or annuity contracts from the insurer or agent from whom you purchased the policy or annuity contract.

(If you are purchasing an annuity, clauses (1), (2), and (3) above would not apply to the new annuity contract.)

**THE INSURANCE OR ANNUITY I INTEND TO PURCHASE FROM AMERICAN NATIONAL MAY REPLACE OR ALTER EXISTING LIFE INSURANCE POLICY(IES) OR ANNUITY CONTRACT(S).** The following policy(ies) or annuity contract(s) may be replaced as a result of the transaction:

Insurer	Insured
as it appears on the policy or contract	as it appears on the policy contract
_____	_____
_____	_____
Policy or Contract Number	Insured Birth Date
_____	_____
_____	_____

The proposed policy or contract is:

\_\_\_\_\_ \$ \_\_\_\_\_  
Type of Policy or Contract - Generic Name Face Amount

\_\_\_\_\_ Date  
Signature of Applicant

\_\_\_\_\_ City State  
Address of Applicant

\_\_\_\_\_

(Applicant - please print or type)

prior to taking and application and that I am leaving a signed copy for applicant.

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

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

**NOTE: IMPORTANT STATEMENT ON NEXT PAGE**



## DEFINITIONS

**PREMIUMS:** Premiums are the payments you make in exchange for an insurance policy or annuity contract. They are unlike deposits in a savings or investment program, because if you drop the policy or contract, you might get back less than paid in.

**CASH SURRENDER VALUE:** This is the amount of money you can get in cash if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

**LAPSE:** A life insurance policy may lapse when you do not pay the premiums within the grace period. If you had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

**SURRENDER:** You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. Whenever a policy has a cash surrender value, you can get it in cash if you return the policy to the company with a written request. Most insurers will also let you exchange the value of the policy for paid-up or extended term insurance.

**CONVERT TO PAID-UP INSURANCE:** This means you use your cash surrender value to change your insurance to a paid-up policy with the same insurer. The death benefit generally will be lower than under the old policy, but you will not have to pay any more premiums.

**PLACE ON EXTENDED TERM:** This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before. However, you will only be covered for a specified period of time stated in the policy.

**BORROW POLICY LOAN VALUES:** If your life insurance policy has a cash surrender value, you can almost always borrow all or part of it from the insurer. Interest will be charged according to the terms of the policy, and if the loan with unpaid interest ever exceeds the cash surrender value, your policy will be surrendered. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

**EVIDENCE OF INSURABILITY:** This means proof that you are an acceptable risk. You have to meet the insurer's standards regarding age, health, occupation, etc., to be eligible for coverage.

**INCONTESTABLE CLAUSE:** This says that after two years, depending on the policy or insurer, the life insurer will not resist a claim because you made a false or incomplete statement when you applied for the policy. For the early years, though, if there are wrong answers on the application and the insurer finds out about them, the insurer can deny a claim as if the policy had never existed.

**SUICIDE CLAUSE:** This says that if you commit suicide after being insured for less than two years, depending on the policy and insurer, your beneficiaries will receive only a refund of the premiums that were paid.



# Suitability Acknowledgement for Minnesota

NF

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

page 1 of 1

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



*Complete Section 1 and 2.*

This form must be completed for each person who is purchasing an insurance product. **Provide the appropriate information and return the completed form to American National Insurance Company at the address shown above.**

## 1 Owner/Applicant Information

Owner/Applicant Name (please print) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Joint Owner/Applicant Name (please print) \_\_\_\_\_ Social Security Number \_\_\_\_\_

## 2 Agent Acknowledgement

*Acknowledgement of Responsibility for Suitability Recommendation*

I have reasonable grounds for believing that the recommendation for this customer to purchase an insurance product is suitable based upon reasonable inquiry concerning the person's insurance objectives, financial situation and needs, age and other relevant information.

Agent Name (please print) \_\_\_\_\_ Telephone # \_\_\_\_\_

Agent/Producer Signature \_\_\_\_\_ Date \_\_\_\_\_





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

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

F

page 1 of 3

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



## READ THIS NOTICE VERY CAREFULLY

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

### AIDS:

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

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

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

The symptoms of AIDS may include the following:

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

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

### PRE-TESTING CONSIDERATIONS

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

### MEANING OF POSITIVE TEST RESULT

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

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



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

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

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

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

### **CONFIDENTIALITY OF TEST RESULTS**

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

### **NOTIFICATION OF TEST RESULTS**

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



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

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

page 3 of 3

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



**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 \_\_\_\_\_



## **Life Insurance Buyer's Guide**

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

---

---

page 1 of 4

---

### ***Prepared by the National Association of Insurance Commissioners***

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

This guide does not endorse any company or policy.

Reprinted By:





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

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

## **Important Things to Consider**

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

## **Buying Life Insurance**

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

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

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

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

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

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

## **What About the Policy You Have Now?**

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

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

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



## How Much Do You Need?

Here are some questions to ask yourself:

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

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

## What is the Right Kind of Life Insurance?

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

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

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

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

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

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

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

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



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

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

## Life Insurance Illustrations

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

## Finding a Good Value in Life Insurance

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

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

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

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