



# Tips for Completing the Life Application (Form 10193)

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

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

*This instruction section is not part of the application.*

## General Instructions

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

### Section 1

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

**t:** *US Citizen verification*

### Section 10

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

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

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

### Section 13

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

### Section 14

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

### Section 18

**a-n:** *Insurance History and Non-Medical Hazards*

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

## Special Rider Instructions – Section 9 of the Application

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

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

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



## Conditional Receipts

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

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

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

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



# Application for Life Insurance

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



## 1. PRIMARY PROPOSED INSURED

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

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

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

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

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

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

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

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

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

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

## 2. ADDITIONAL PROPOSED INSURED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

**8. PRODUCT INFORMATION**

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

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

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

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

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

**If Participating Whole Life**

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

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

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

**If Indexed Universal Life**

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

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

**If Variable Universal Life**

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

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



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

a. Optional benefits/riders:

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

Other: Type of Rider, Name of insured, Amount of insurance

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

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
_____	_____	_____	_____	_____

  

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.)

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

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

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

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

**Primary Proposed Insured**

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

**Additional Proposed Insured**

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





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

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

I understand that:

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

**APPLICATION DECLARATIONS AND AGREEMENTS**

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

**FRAUD STATEMENT**

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

**FCRA / MIB ACKNOWLEDGEMENT**

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

**APPLICATION SIGNATURES**

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

**For Indexed Universal Life:**

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

**For Variable Universal Life:**

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

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

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

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

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

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





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

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

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

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

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

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

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





**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 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](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: Replacement of Life Insurance or Annuities

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



Do you have existing insurance or annuity coverage?

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

Yes; please continue.

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

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

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

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

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

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

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

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

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

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

\_\_\_\_\_  
Date



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

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
-----------------	-------------------------	---------	----------------------------------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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

**SPECIFIC REASON FOR REPLACING EXISTING POLICY WITH NEW PROPOSED POLICY:**

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

**You SHOULD NOT take action to terminate, assign or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you.**

Remember, where a replacement is involved, the policy owner has the right to return the policy within thirty (30) days of delivery of the contract and receive a full refund of all premiums. In the case of a variable policy or contract, or in the case of a contract with a market value adjustment, the cash surrender value plus the fees or other charges deducted from the gross premium will be returned, if the applicant decides to return the contract within the 30 day allotted time period.

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

**PREMIUMS:**

Are they affordable?

Could they change?

Are they guaranteed on your current policy?

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

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

**POLICY VALUES:**

Does your current policy pay dividends?

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

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

What surrender charges do the policies have?

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

Does the new policy provide more insurance coverage?

**INSURABILITY:**

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

You may need a medical exam for a new policy.

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

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

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

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

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



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

Will you pay surrender charges on your old contract?

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

Have you compared the contract charges or other policy expenses?

## OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

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

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

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

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

### Statement of Policy Regarding Replacements

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

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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



## HIV Test Informed Consent Form

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

page 1 of 2

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



In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

### Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

### PRE-TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

### DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider. Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the result for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

### TEST RESULTS:

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider. HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be 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.

### OTHER SOURCES OF INFORMATION:

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

### CONSENT FOR HIV TESTING:

I have read and I understand this HIV test informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the day of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within 90 (ninety) day period.



In the event of a positive test result:

\_\_\_\_\_ Send the result to me at:

\_\_\_\_\_  
(Address)

\_\_\_\_\_ I authorize American National Insurance Company, to send the result to another person:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_ I authorize American National Insurance Company, to send the result to the following physician or health care provider:

\_\_\_\_\_  
(Physician's Name)

\_\_\_\_\_  
(Address)

**AUTHORIZATION**

\_\_\_\_\_  
Name of Application

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian, if any

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person obtaining consent

\_\_\_\_\_  
Date



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

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

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page 1 of 4

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

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This guide does not endorse any company or policy.

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

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

## **Important Things to Consider**

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

## **Buying Life Insurance**

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

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

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

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

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

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

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

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

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

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



## 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.



## Summary and Disclosure Notice for Accelerated Benefits

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

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**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: Replacement of Life Insurance or Annuities

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



Do you have existing insurance or annuity coverage?

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

Yes; please continue.

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

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

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

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

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

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

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

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

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

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

\_\_\_\_\_  
Date





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

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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

**SPECIFIC REASON FOR REPLACING EXISTING POLICY WITH NEW PROPOSED POLICY:**

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

**You SHOULD NOT take action to terminate, assign or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you.**

Remember, where a replacement is involved, the policy owner has the right to return the policy within thirty (30) days of delivery of the contract and receive a full refund of all premiums. In the case of a variable policy or contract, or in the case of a contract with a market value adjustment, the cash surrender value plus the fees or other charges deducted from the gross premium will be returned, if the applicant decides to return the contract within the 30 day allotted time period.

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

**PREMIUMS:**

Are they affordable?

Could they change?

Are they guaranteed on your current policy?

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

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

**POLICY VALUES:**

Does your current policy pay dividends?

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

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

What surrender charges do the policies have?

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

Does the new policy provide more insurance coverage?

**INSURABILITY:**

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

You may need a medical exam for a new policy.

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

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

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

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

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



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

Will you pay surrender charges on your old contract?

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

Have you compared the contract charges or other policy expenses?

## OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

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

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

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

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

### Statement of Policy Regarding Replacements

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

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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



## HIV Test Informed Consent Form

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

page 1 of 2

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



In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

### Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

### PRE-TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

### DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider. Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the result for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

### TEST RESULTS:

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider. HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be 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.

### OTHER SOURCES OF INFORMATION:

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

### CONSENT FOR HIV TESTING:

I have read and I understand this HIV test informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the day of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within 90 (ninety) day period.



In the event of a positive test result:

\_\_\_\_\_ Send the result to me at:

\_\_\_\_\_

(Address)

\_\_\_\_\_ I authorize American National Insurance Company, to send the result to another person:

\_\_\_\_\_

(Name)

\_\_\_\_\_

(Address)

\_\_\_\_\_ I authorize American National Insurance Company, to send the result to the following physician or health care provider:

\_\_\_\_\_

(Physician's Name)

\_\_\_\_\_

(Address)

**AUTHORIZATION**

\_\_\_\_\_

Name of Application

\_\_\_\_\_

Signature of Applicant

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Legal Guardian, if any

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Person obtaining consent

\_\_\_\_\_

Date