Application for Individual Life Insurance

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* A P P *

Part 1:

Note: Complete and thorough answers to all of the following questions will help to ensure efficient and accurate processing of your application. For any question that requires additional detail, you may attach a sheet of paper, if necessary.

1. Primary Proposed Insured

a. Name: Last | First | M.I. | b. Birthplace: City | State | Country

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number:

f. Gender: ☐ Male ☐ Female g. Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

h. Residence Address: Number/Street | City | State | ZIP

i. Years at this Residence: | j. Phone Number: Home ( ) | Cell Phone: ( ) | If a phone interview is needed, which is preferred number? ☐ Home ☐ Cell

k. Annual Income: $ | Net Worth: $ | E-mail Address:

l. Occupation/Job Title: | m. Employer Name: | n. Type of Business:

o. Job Duties *(Be Specific)*: | p. Duration of Employment:

q. Business Address: Number/Street | City | State | ZIP

r. Are you a U.S. Citizen? ☐ Yes ☐ No

If No, are you a legal permanent resident of the U.S.? ☐ Yes ☐ No

If No, do you have a VISA? ☐ Yes ☐ No

If Yes, type of VISA: _____. Expiration date: _____.

If No, please complete Residency Questionnaire.

2. Juvenile Primary Proposed Insured *(To be completed when Primary Proposed Insured is a juvenile under state law. Do not complete if applying for Children's Term Rider.)*

a. Is the owner a parent of the proposed juvenile insured? ☐ Yes ☐ No

If No, is the owner a grandparent of the proposed juvenile insured? ☐ Yes ☐ No

If No, is the owner a legally appointed guardian who is responsible for the financial support of the proposed juvenile insured? ☐ Yes ☐ No

b. What is the combined annual income and net worth of the proposed juvenile insured's parents (or legally appointed guardian)?

Annual Income: $ | Net Worth: $

c. How much Life Insurance does each parent (or legally appointed guardian) have on his/her own life?

Mother: $ | Father: $ | Guardian: $

d. Are there any other minor siblings in the home? ☐ Yes ☐ No

If Yes, do the siblings have the same amount of coverage in force/applied for? ☐ Yes ☐ No

If No, explain: _____

e. If the proposed juvenile insured is under the age of 1, was the birth considered premature? ☐ Yes ☐ No

f. If the proposed juvenile insured is under the age of 1, what was his or her birth weight? _____ lbs. _____ oz.

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3. Additional Proposed Insured

a. Name: Last | First | M.I. | b. Birthplace: City | State | Country

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number:

f. Gender: ☐ Male ☐ Female g. Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

h. Residence Address: Number/Street | City | State | ZIP

i. Years at this Residence: | j. Phone Number: Home (____) | Cell Phone: (____) | If a phone interview is needed, which is preferred number? ☐ Home ☐ Cell

k. Annual Income: $ | Net Worth: $ | Relationship to primary proposed insured

l. Occupation/Job Title: | m. Employer Name: | n. Type of Business:

o. Job Duties *(Be Specific)*: | p. Duration of Employment:

q. Business Address: Number/Street | City | State | ZIP

r. Are you a U.S. Citizen? ☐ Yes ☐ No

If No, are you a legal permanent resident of the U.S.? ☐ Yes ☐ No

If No, do you have a VISA? ☐ Yes ☐ No

If Yes, type of VISA: _____. *Expiration date:* _____.

If No, please complete Residency Questionnaire.

4. Primary Ownership *(if other than Primary Proposed Insured)*

If owner is an individual:

a. Name: Last | First | M.I. | b. Relationship of the Primary Owner to Primary Proposed Insured:

c. Gender: ☐ Male ☐ Female

d. Date of Birth: Month/Day/Year | e. Social Security/Tax ID Number:

f. Residence Address: Number/Street | City | State | ZIP

Phone Number: (____) | E-mail Address:

If owner is a business:

a. Name of Business: | b. Date Established: | c. Tax ID Number:

d. Business Address: Number/Street | City | State | ZIP

If owner is a trust:

a. Name of Trust: | b. Date Trust was created:

c. Type of Trust: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Other *(Explain)* _____

5. Contingent Ownership *(Optional ownership, if any)*

a. Name: Last | First | M.I. | b. Relationship of the Contingent Owner to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Social Security/Tax ID Number:

6. Designated Third Party Addressee *(This person will receive notices for past due premiums and pending policy termination.)*

a. Name: Last | First | M.I.

b. Residence Address: Number/Street | City | State | ZIP

7. Primary Beneficiary *(Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life Insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)*

If beneficiary is an individual:

a. Name: Last | First | M.I. | b. Relationship of the Beneficiary to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: | f. Percentage Payable: %

a. Name: Last | First | M.I. | b. Relationship of the Beneficiary to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: | f. Percentage Payable: %

a. Name: Last | First | M.I. | b. Relationship of the Beneficiary to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: | f. Percentage Payable: %

If beneficiary is a business:

a. Name of Business: | b. Date Established: | c. Tax ID Number:

If beneficiary is a trust:

a. Name of Trust: | b. Date Trust was created:

c. Type of Trust: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Other *(Explain)*

8. Contingent Beneficiary *(Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)*

a. Name: Last | First | M.I. | b. Relationship of the Contingent Beneficiary to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: | f. Percentage Payable: %

a. Name: Last | First | M.I. | b. Relationship of the Contingent Beneficiary to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: | f. Percentage Payable: %

9. Children Proposed for Term Rider Coverage

a. Name: Last | First | M.I. | b. Relationship of the Proposed Child to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number: | f. Gender: ☐ Male ☐ Female

a. Name: Last | First | M.I. | b. Relationship of the Proposed Child to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number: | f. Gender: ☐ Male ☐ Female

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(Continuation of Section 9)

a. Name: Last | First | M.I. | b. Relationship of the Proposed Child to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number: | f. Gender: ☐ Male ☐ Female

g. Has the name of any child age 18 or younger been omitted? ☐ Yes ☐ No
If Yes, explain. ______

h. If child is under the age of 1, was the birth considered premature? ☐ Yes ☐ No
If Yes, how many weeks premature? ______ weeks
Duration of hospitalization? ______ weeks

i. If child is under the age of 1, what was his/her birth weight? ______ lbs. ______ oz.

j. Has any child proposed for term rider coverage **EVER** been diagnosed or treated by a member of the medical profession for any disease or disorder of: the heart; cancer; tumor; seizure disorder/epilepsy; diabetes; respiratory disease; birth defect; psychiatric or behavior abnormality including attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)? *(If Yes, provide details below, including child's name and disease or disorder.)* ☐ Yes ☐ No

10. Purpose of Coverage *(If amount of insurance is greater than $250,000)*

a. If personal coverage: ☐ Income Replacement ☐ Debt Repayment ☐ Estate Planning/Conservation ☐ Other ______

b. If business coverage: ☐ Key Person ☐ Buy/Sell ☐ Deferred Compensation ☐ Loan Protection ☐ Other ______

11. Other Insurance and Replacements

a. Do you have existing life insurance or annuity coverage with this, or any other company? (*If Yes, complete Other Insurance and Replacement Details.)* ☐ Yes ☐ No

b. If Yes, will the insurance applied for replace, change, or use cash values of any existing life insurance or annuity issued by any company? (*If Yes, complete Other Insurance and Replacement Details.)* ☐ Yes ☐ No

c. In the **past 6 months**, has any proposed insured applied for - or is any proposed insured currently contemplating applying for - other life insurance with this, or any other company? *(If Yes, state how much and to whom.)* ☐ Yes ☐ No

d. Other Insurance and Replacement Details:

Full Company Name: ______ | Policy/Contract Number: ______ | ☐ Life ☐ Annuity | Status: ☐ In Force Issue Date: ______ ☐ Pending Application Date: ______

Insured/Annuitant's Name: ______ | Plan: ______ | Amount: $ ______ | Replacement? ☐ Yes ☐ No | 1035 Exchange? ☐ Yes ☐ No

Full Company Name: ______ | Policy/Contract Number: ______ | ☐ Life ☐ Annuity | Status: ☐ In Force Issue Date: ______ ☐ Pending Application Date: ______

Insured/Annuitant's Name: ______ | Plan: ______ | Amount: $ ______ | Replacement? ☐ Yes ☐ No | 1035 Exchange? ☐ Yes ☐ No

Full Company Name: ______ | Policy/Contract Number: ______ | ☐ Life ☐ Annuity | Status: ☐ In Force Issue Date: ______ ☐ Pending Application Date: ______

Insured/Annuitant's Name: ______ | Plan: ______ | Amount: $ ______ | Replacement? ☐ Yes ☐ No | 1035 Exchange? ☐ Yes ☐ No

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12. Insurance History and Non-Medical Hazards

a. In the **past 5 years**, has any proposed insured 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? *(If Yes, provide details below.)*..... ☐ Yes ☐ No

b. In the **past 5 years**, has any proposed insured engaged in – or within the **next 2 years** does any proposed insured intend to engage in - flights as a pilot, student pilot, crew member, or observer? *(If Yes, complete Aviation Questionnaire.)*..... ☐ Yes ☐ No

c. In the **past 5 years**, has any proposed insured engaged in - or within the **next 2 years** does any proposed insured intend to engage in - mountain climbing, rock climbing, racing, SCUBA diving, hang gliding, ballooning, or sky diving? *(If Yes, complete appropriate questionnaire.)*.... ☐ Yes ☐ No

d. In the **past 10 years**, has any proposed insured plead guilty or been convicted of a felony or have any felony charges currently pending? *(If Yes, provide details below.)*..... ☐ Yes ☐ No

e. In the **past 12 months**, has any proposed insured been or are you currently on probation or parole? *(If Yes, provide start and end date.)*..... ☐ Yes ☐ No

f. Do you intend to travel or reside outside the U.S. or Canada in the **next 2 years**? ..... ☐ Yes ☐ No

If Yes, where? _____

13. Driving History

Primary Proposed Insured:

a. Do you have a driver's license? ..... ☐ Yes ☐ No

If Yes, what is the driver's license number and issue state?.....DL#: _____ State: _____

*If No, have you **EVER** had a driver's license?* ..... ☐ Yes ☐ No

b. In the **past 5 years**, have you been convicted of any of the following?

- driving under the influence or driving while impaired ..... ☐ Yes ☐ No

If Yes, provide date and details regarding sentence: ..... Date: _____ Details: _____

Additional Proposed Insured:

a. Do you have a driver's license? ..... ☐ Yes ☐ No

If Yes, what is the driver's license number and issue state?.....DL#: _____ State: _____

*If No, have you **EVER** had a driver's license?* ..... ☐ Yes ☐ No

b. In the **past 5 years**, have you been convicted of any of the following?

- driving under the influence or driving while impaired ..... ☐ Yes ☐ No

If Yes, provide date and details regarding sentence:.....Date: _____ Details: _____

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Part 2:

14. Physician/Facility that has Most Complete Medical Records on Proposed Insured

Primary Proposed Insured:

a. Physician/Facility Name:

b. Address: Number/Street | City | State | ZIP | c. Phone:

d. Date Last Seen: | e. Reason:

Additional Proposed Insured:

a. Physician/Facility Name:

b. Address: Number/Street | City | State | ZIP | c. Phone:

d. Date Last Seen: | e. Reason:

15. Build

Primary Proposed Insured:

a. What is the proposed insured's height and weight? ..... _____ Feet _____ Inches _____ Pounds

b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and *delivery? (If Yes, provide details below.)*..... ☐ Yes ☐ No

Additional Proposed Insured:

a. What is the proposed insured's height and weight? ..... _____ Feet _____ Inches _____ Pounds

b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and *delivery? (If Yes, provide details below.)*..... ☐ Yes ☐ No

16. Tobacco Use Information

Primary Proposed Insured:

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? ..... ☐ Yes ☐ No

If Yes, provide details for all types of nicotine/tobacco used.

Type: _____	Type: _____	Type: _____
Frequency:	Frequency:	Frequency:
☐ Daily	☐ Daily	☐ Daily
☐ Occasionally/Socially	☐ Occasionally/Socially	☐ Occasionally/Socially
☐ No Longer Use	☐ No Longer Use	☐ No Longer Use
Date of Last Use: _____	Date of Last Use: _____	Date of Last Use: _____

Additional Proposed Insured:

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? ..... ☐ Yes ☐ No

If Yes, provide details for all types of nicotine/tobacco used.

Type: _____	Type: _____	Type: _____
Frequency:	Frequency:	Frequency:
☐ Daily	☐ Daily	☐ Daily
☐ Occasionally/Socially	☐ Occasionally/Socially	☐ Occasionally/Socially
☐ No Longer Use	☐ No Longer Use	☐ No Longer Use
Date of Last Use: _____	Date of Last Use: _____	Date of Last Use: _____

17. Human Immunodeficiency Virus (AIDS)

(For questions 17 through 21c, provide details in Section 22.)

Has any proposed insured **EVER** been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired immune Deficiency Syndrome (AIDS)?..... ☐ Yes ☐ No

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18. Medical History - Lifetime

Has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding…

a. Heart disease, including: heart attack; coronary artery blockage; angina; heart failure; cardiomyopathy; irregular heartbeat; or disease or disorder of the heart? ☐ Yes ☐ No
b. Stroke, Transient Ischemic Attack (TIA/mini-stroke), carotid artery disease, peripheral vascular disease, poor circulation, aneurysm, or any other disease or disorder of the blood vessels? ☐ Yes ☐ No
c. Cancer, tumor, abnormal growth, lump, mass, melanoma, lymphoma, or leukemia? ☐ Yes ☐ No
d. Anemia, clotting disorder, or any disease or disorder of the blood? ☐ Yes ☐ No
e. Any diseases or disorders of the immune system except for those related to Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No

19. Medical History - Last 10 Years

In the past 10 YEARS, has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding…

a. High blood pressure? ☐ Yes ☐ No
b. Diabetes or abnormal blood sugar to include high blood sugar or low blood sugar? ☐ Yes ☐ No
c. Depression, anxiety, attention deficit/hyperactivity disorder, bipolar disorder, schizophrenia, post-traumatic stress disorder, or psychiatric treatment? ☐ Yes ☐ No
d. Asthma, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, sleep apnea, tuberculosis, or any disease or disorder of the lungs? ☐ Yes ☐ No
e. Gastrointestinal bleeding, ulcers, Crohn's disease, Barrett's esophagus, ulcerative colitis, hepatitis, cirrhosis, colon polyps, or any other disease or disorder of the esophagus, stomach, intestines/colon, rectum, liver or pancreas? ☐ Yes ☐ No
f. Any disease or disorder of the kidneys, urinary bladder, blood in urine, protein in urine, prostate disorder including abnormal PSA (prostate specific antigen), ovaries, uterus, or cervix including abnormal Pap smear? ☐ Yes ☐ No
g. Disorder of the thyroid, pituitary gland, parathyroid glands, or adrenal glands? ☐ Yes ☐ No
h. Arthritis, fibromyalgia, chronic pain, chronic back pain, or any joint or muscle condition? ☐ Yes ☐ No
i. Lupus, scleroderma, any connective tissue disease, or any autoimmune disorder? ☐ Yes ☐ No
j. Seizures/epilepsy, tremors, multiple sclerosis, paralysis, Alzheimer's, dementia, Parkinson's, blindness or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

20. Drugs/Alcohol History

In the past 10 YEARS, has any proposed insured…

a. Used marijuana in any form? ☐ Yes ☐ No
b. Used cocaine, barbiturates, crack, ecstasy, methamphetamine, heroin, LSD or hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No
c. Been addicted to prescription medication or been advised by a licensed medical professional to discontinue habit forming drugs? ☐ Yes ☐ No
d. Been advised by a licensed medical professional to cease or reduce alcohol use or been advised to get medical treatment, or undergone any medical treatment, counseling, or hospitalization for alcoholism, excessive alcohol use or abuse? ☐ Yes ☐ No

21. Medical History - Last 5 Years

In the past 5 YEARS, has any proposed insured…

a. Had any consultation, testing, surgery or investigation scheduled or recommended by a member of the medical profession that has not yet been completed (excluding routine checkups, preventative care, pregnancy and HIV)? ☐ Yes ☐ No
b. Applied for or received any disability benefits (other than maternity) from any insurance company, government, employer, or other source? ☐ Yes ☐ No
c. Taken any prescription medications other than what has already been disclosed on the application? ☐ Yes ☐ No

22. Medical History Explanations

(Give full details below of all Yes answers to questions in Sections 17 through 21.)

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

Question: Person: | Reason, Condition, Disease, Injury, Medication(s), Etc.: | Date of Diagnosis:

Name of Attending Physician: | Attending Physician Address: Number/Street | City | State | Phone #:

23. Family History *(If amount of insurance is greater than $100,000)*

Primary Proposed Insured:

Father:

a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma? ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is father deceased? ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Mother:

a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma? ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is mother deceased? ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Siblings:

a. How many siblings do you have? _____

b. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma? ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

c. Are any siblings deceased? ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Additional Proposed Insured:

Father:

a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma? ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is father deceased? ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Mother:

a. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma? ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is mother deceased? ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Siblings:

a. How many siblings do you have? _____

b. Been diagnosed or treated by a member of the medical profession for heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma? ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

c. Are any siblings deceased? ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

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Fraud Statement

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

Application Signatures

By signing this application I agree to the following:

- I have read the application and all statements and answers as they pertain to me and such statement and answers are true and complete to the best of my knowledge and belief.
- The statements and answers in this application are the basis for and will become part of any policy issued by American National Insurance Company and no information about any person in the application will be considered to have been given to American National Insurance Company unless it is stated in the application.
- If there are any changes in the statements or answers given in this application between the date of application and the delivery of the policy, I am responsible for notifying American National Insurance Company.
- I understand the agent does not have American National Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this application or the policy;
- I understand that American National Insurance Company may issue a policy different than requested in this application subject to my approval and acceptance with the exception that no change in: the amount of insurance; classification; plan of insurance; or benefits will be effective unless I have provided my written consent.
- Only the president, a vice president, or secretary of American National Insurance Company has the authority to waive any of its rights or requirements.
- American National Insurance Company will have no liability until:
  - A policy is issued on this application and delivered to and accepted by the Owner; and
  - The first premium due is paid in full while each proposed insured is alive and in the same health as indicated in this application.
- If Conditional or Premium Receipt was issued:
  - I hereby certify that I have read and received the Conditional or Premium Receipt and agree to its terms.
  - I understand that American National Insurance Company will not permit acceptance of my deposit or issuance of the Conditional or Premium Receipt unless this statement is true.
- I acknowledge that I have received and read the Authorization to Release, Obtain and Disclose Information and authorize American National Insurance Company to obtain personal information about me from the third-party provider(s) explained in the Authorization to Release, Obtain and Disclose Information.
- I understand that federal law requires sufficient information to identify the parties to the purchase of a policy and that failure to provide such information could result in: the policy not being issued; being delayed; unprocessed transaction requests; or policy termination.
- If the Owner is an entity:
  - The individuals signing on behalf of the entity purchasing the policy and are authorized and empowered to individually or collectively:
    - enter into contracts and financial transactions including but not limited to the purchase of life insurance;
    - to make any subsequent withdrawals or surrenders; and
    - exercise all ownership rights under any issued policy in the entity's name.
  - The entity is duly organized and existing in compliance with all laws and regulations.
  - The entity will notify American National Insurance Company in writing of a change in or revocation of authorized individuals, or any change in the entity's status that would cause any of the statements in the application to be incorrect or incomplete.
  - The entity has consulted an independent tax and/or legal advisor for more information deemed necessary to understand the tax treatment of the policy.
  - The authorized individuals and the entity agree to indemnify American National Insurance Company, its affiliates or representatives for liability of any kind arising out of or related to any acts or omissions taken by American National Insurance Company upon their instructions and in reliance on their representatives to American National Insurance Company in connection with the policy.

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

Signature of licensed agent

X _____

Print agent's name

_____

Agent's state license number

_____

Agent's company personal code

_____

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

X _____

Signature of additional person proposed for insurance

X _____

Signature of additional person proposed for insurance

X _____

Signature of owner if other than proposed insured

X _____

If the owner is a corporation, partnership, or trust, title of the officer is required

_____

Agent's Report

NF

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* A G R *

1. Soliciting Agent's Report

I certify that I asked the Proposed Insured(s) each question on the application and accurately recorded each answer provided to me by the Proposed Insured(s).

a. How long have you personally known the proposed insured? _____ Years _____ Months

b. By whom will premiums be paid? ☐ Owner ☐ Applicant ☐ Other

c. If beneficiary is not a relative, explain insurable interest. _____

d. Are you aware of anything about the health, habits, hobbies, or other factors that might affect the insurability of the proposed insured? ☐ Yes ☐ No

(If Yes, explain.) _____

e. Did you determine this applicant's objective and/or financial need for this insurance? *(If No, explain.)* ☐ Yes ☐ No

_____

f. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ☐ Yes ☐ No

g. As agent, have you complied with state replacement regulations? ☐ Yes ☐ No

h. Have you submitted paperwork for a change in reporting hierarchy or commission arrangement for this application? ☐ Yes ☐ No

If Yes, please describe change: _____ *New Upline:* _____

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 Address: | Telephone Number:

X _____ | _____ | (_____) _____

2. Special Issue Instructions to Administrative Office

a. Additional Policy? Plan: _____ Amount: $ _____

b. Alternate Policy? Plan: _____ Amount: $ _____

c. Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National? ☐ Yes ☐ No

d. Are any other applications being submitted on the proposed insured's family members or business partners that need to be held and issued together? *(If Yes, provide names and date of birth.)* ☐ Yes ☐ No

_____

e. 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 the Split Credit Authorization form.)

Agent: _____ *Personal code or number:* _____

Agent: _____ *Personal code or number:* _____

f. Special Instructions: _____

3. Notes to Underwriter

_____

_____

_____

4. Requirements Ordered: See Current Underwriting Guidelines

Indicate which of the following was (were) ordered by producer, agency, or general agent:

☐ Oral Fluid Test collected by agent? Date Collected: _____ Lab ticket attached or affix barcode here: _____

☐ Automatic exam/lab requirements?

Name of approved paramed company? _____

Were medical records (APS) ordered by producer, agency or general agent? ☐ Yes ☐ No

If Yes, give physician/facility's name: _____

If the medical records have been paid for, attach invoice.

Supplemental Application for Signature Term Life

An Individual Nonparticipating Term Life Product

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* S U P *

Product Selections

Please select the plan applied for below:

- ☐ Signature Term Annual Renewable Term
- ☐ Signature Term 10-Year Level Term
- ☐ Signature Term 15-Year Level Term
- ☐ Signature Term 20-Year Level Term
- ☐ Signature Term 30-Year Level Term

Amount of Insurance $ _____
(Minimum of $50,000)

Optional Riders / Benefits *(Additional costs may apply.)*

- ☐ Children's Term Rider ..... $ _____
  Complete Section 9 of Application.
- ☐ Disability Waiver of Premium Rider

Premium

Planned Premium Amount..... $ _____

Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

- ☐ Do not change the Premium Amount; change the Amount of Insurance.
- ☐ Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age _____ Issue Date _____

Important Notice

You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.

Supplemental Application for Universal Life

F

An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product

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

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* S U P *

Product Selections

Please select the plan applied for below:

■ Executive Universal Life

Specified Amount of Insurance $ _____
(Minimum of $25,000)
Life Insurance Qualification Test:
☑ *Guideline Premium Test ("GPT")*

Death Benefit Option *(Must select one)*

☐ Option A - Specified Amount
☐ Option B - Specified Amount plus Accumulation Value
☐ Option C - Specified Amount plus Return of Premiums

Optional Riders / Benefits *(Additional costs may apply.)*

Executive Universal Life

☐ Children's Term Rider ..... $ _____
Complete Section 9 of Application.

☐ Disability Waiver of Minimum Premium Rider
(May not be combined with any other disability waiver of premium.)

☐ Disability Waiver of Stipulated Premium Rider ..... $ _____
(May not be combined with any other disability waiver of premium.)

☐ Guaranteed Increase Option Rider ..... $ _____
($10,000 - $25,000 in $1,000 increments.)

Premium

Planned Periodic Premium Amount..... $ _____

Initial Premium (if different than Planned Periodic Premium Amount)..... $ _____

☐ *Check here if initial premium will be applied from a 1035 Exchange.*

Special Requests

Special Dating Instructions: Issue Age _____ Issue Date _____

Important Notice

You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.

Supplemental Application for Indexed Universal Life Series

F

An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product

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

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* S U P *

Product Selections

Please select the plan applied for below:

- ☐ Signature Performance Indexed Universal Life
- ☐ Signature Performance Indexed Universal Life Unisex
  - ☐ *Product to be used in a group retirement plan (not including 457/403b market)*

Amount of Insurance $ _____
(Minimum of $25,000)

Life Insurance Qualification Test:
- ☑ *Guideline Premium Test ("GPT")*

Death Benefit Option *(Must select one)*

- ☐ Option A - Specified Amount
- ☐ Option B - Specified Amount plus Accumulation Value
- ☐ Option C - Specified Amount plus Return of Premiums

Premium Allocation

All crediting strategies have a one-year term. Indexed Crediting Strategies are based on the Declared Index. When allocating premiums, whole percentages must be used and the total must equal 100%.

Fixed Account ..... _____%

Indexed Crediting Strategies:

Point to Point Uncapped with Interest Rate Spread ..... _____%

Point to Point with Cap ..... _____%

Point to Point with a Cap and Low Multiplier ..... _____%

Point to Point with a Cap and High Multiplier ..... _____%

Total (must equal 100%) _____%

Optional Riders / Benefits *(Additional costs may apply.)*

Signature Performance Indexed Universal Life

- ☐ Children's Term Rider ..... $ _____
  Complete Section 9 on Application.
- ☐ Disability Waiver of Minimum Premium Rider
  (May not be combined with any other disability waiver of premium.)
- ☐ Disability Waiver of Stipulated Premium Rider ..... $ _____
  (May not be combined with any other disability waiver of premium.)
- ☐ Guaranteed Increase Option Rider ..... $ _____
  ($10,000 - $25,000 in $1,000 increments.)

Signature Performance Indexed Universal Life Unisex

- ☐ Disability Waiver of Minimum Premium Rider
  (May not be combined with any other disability waiver of premium.)
- ☐ Disability Waiver of Stipulated Premium Rider ..... $ _____
  (May not be combined with any other disability waiver of premium.)

Premium

Planned Premium Amount.....$ _____

Initial Premium (if different than Planned Premium Amount).....$ _____

☐ *Check here if initial premium will be applied from a 1035 Exchange.*

Special Requests

Special Dating Instructions: Issue Age _____ Issue Date _____

Important Notice

You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.

By signing this application, I agree to the following:

- **I am applying for an indexed life insurance policy.**
- **The interest credited to the policy may be affected by the performance of an index. This does not mean the return will equal that of the index.**
- **The policy does not directly participate in any stock or equity investments or index; I am not buying ownership interest in any stock or index.**
- **I understand that the guaranteed interest rate credited to any available index fund will never be less than 0%.**

Supplemental Application for Signature Guaranteed Universal Life

F

An Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* S U P *

Product Selections

Please select the plan applied for below:

☑ Signature Guaranteed Universal Life

Amount of Insurance $ _____
(Minimum of $25,000)

Life Insurance Qualification Test:

☑ *Cash Value Accumulation Test ("CVAT")*

Death Benefit Option

☑ Option A - Specified Amount

Duration of Death Benefit Guarantee

☐ Coverage to 95 ☐ Coverage to 100 ☐ Other Age _____

☐ Coverage to 105 ☐ Coverage to 121

Optional Riders / Benefits *(Additional costs may apply.)*

☐ Children's Term Rider ..... $ _____
Complete Section 9 of Application.

☐ Disability Waiver of Stipulated Premium ..... $ _____

Premium

Planned Premium Amount ..... $ _____

Initial Premium Amount (if different than Planned Premium Amount) ..... $ _____

☐ *Check here if initial premium will be applied from a 1035 Exchange.*

Special Requests

Special Dating Instructions: Issue Age _____ Issue Date _____

Important Notice

You are applying for an indeterminate premium product. The initial or current premiums may change and the maximum guaranteed premiums can be charged.

Supplemental Application for Signature Whole Life

An Individual Participating Whole Life Insurance Product

F

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* S U P *

Product Selections

Please select the plan applied for below:

☑ Signature Whole Life

Amount of Insurance $ _____
(Minimum of $10,000)

Automatic Premium Loan Requested? ☐ Yes ☐ No

Dividend Options *(Must select one)*

☐ Cash ☐ Premium Reduction* ☐ Participating Paid-Up Additions ☐ Dividend Accumulation

*Only available with Direct Billing.

If Premium Reduction is selected, You must specify a secondary option:

☐ Cash ☐ Dividend Accumulation ☐ Participating Paid-Up Additions

Optional Riders / Benefits *(Additional costs may apply.)*

☐ Children's Term Rider ..... $ _____

Complete Section 9 of Application.

☐ Disability Waiver of Premium Rider

☐ Guaranteed Insurance Option Rider ..... $ _____

☐ Paid-Up Additions Rider

Planned Modal Premium ..... $ _____

No. of Years ..... _____

OR Single Premium ..... $ _____

☐ Signature Term Rider ..... $ _____

Level Term Period:

☐ *ART* ☐ *10 Year* ☐ *15 Year* ☐ *20 Year* ☐ *30 Year*

(Minimum $25,000 - Maximum 4x base policy)

Name of Proposed Rider Insured: _____

Is the Beneficiary for this rider the same as the Beneficiary for the policy? ..... ☐ Yes ☐ No

If No, please complete the Additional Beneficiary Page and submit with application.

Premium

Planned Premium Amount ..... $ _____

Initial Premium (if different than Planned Premium Amount) ..... $ _____

☐ *Check here if initial premium will be applied from a 1035 Exchange.*

Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

☐ Do not change the Premium Amount; change the Amount of Insurance.

☐ Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age _____ Issue Date _____

Supplemental Application for Limited Pay Whole Life

An Individual Non-Participating Whole Life Insurance Product

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* S U P *

Product Selections

Please select the plan applied for below:

☑ Limited Pay Whole Life

☐ *Product to be used in a group retirement plan (not including 457/403b market)*

Amount of Insurance $ _____
(Minimum of $10,000)

Optional Riders / Benefits *(Additional costs may apply.)*

☐ Disability Waiver of Premium Rider

Premium

Planned Premium Amount.....$ _____

Initial Premium (if different than Planned Premium Amount).....$ _____

☐ *Check here if initial premium will be applied from a 1035 Exchange.*

Special Requests

If all Proposed Insureds are acceptable risks on a nonrated basis, but the Premium Amount listed will not purchase the requested Amount of Insurance:

☐ Do not change the Premium Amount; change the Amount of Insurance.

☐ Do not change the Amount of Insurance; change the Premium Amount.

Special Dating Instructions: Issue Age _____ Issue Date _____

Billing Information

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

F

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* P A C *

1. Billing Data

a. Premium Billing Mode (select one):

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ Single Premium ☐ Bi Weekly (Salary Deduction Only)

b. Premium Payment Method (select one):

☐ **Electronic Fund Transfer (EFT)** – (Choose an option below and complete Section 2)

☐ Draft upon approval and receipt of all outstanding policy requirements. If this option is selected, the effective date of coverage will become the draft date.

☐ Draft on specific day (1-28) _____, after approval and receipt of all outstanding policy requirements. Day specified will determine policy effective date.

☐ **Direct Bill (Monthly Mode not available)**

Fill in name and address where premium notices are to be sent, only if other than the owner.

Name:

Number/Street:

City: State: ZIP: Country:

☐ **Salary Deduction / Franchise / Government Allotment**

Premium amount based on Mode selected above $ _____

Payee Name: _____

Social Security Number: _____

Franchise Number: _____

c. E-mail Address of Premium Payer: _____

2. Electronic Fund Transfer (EFT) Information: Attach "VOID" Check

Name of premium payer:

Name(s) of insured(s):

Account type: ☐ Checking ☐ Savings

Bank name: Bank account number: Bank transit number:

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

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

Date: Month/Day/Year

Signature of premium payer

X _____

Signature of Agent

X _____

Authorization to Release, Obtain and Disclose Information

NF

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

This authorization was designed to comply with the requirements of the Health Insurance Portability and Accountability Act.

I hereby authorize any physician, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, paramedical facility, other medical related facility, information database manager, insurance company, insurance support organization, health plan, group policy holder, benefit plan administrator, employer, state motor vehicle agency, other government agency, consumer reporting agency, and MIB, Inc. to provide the COMPANY, or any employee, representative, affiliate, reinsurer, independent administrator or third party acting on the Company's behalf, any and all information concerning me or any proposed insured, to the extent permitted by state and federal law, including but not limited to:

- entire medical record and any other protected health information;
- diagnosis or treatment of any physical, behavioral or mental condition;
- diagnosis or treatment of any mental illness;
- consultations, surgeries, hospitalizations or confinements;
- HIV, AIDS or ARC related information, including test results;
- serious communicable diseases or infections, including sexually transmitted diseases;
- drug, alcohol or tobacco use;
- consumer reports, including investigative consumer reports;
- driving records; and
- finances, occupations or avocations.

This authorization permits information to be provided electronically, including use of an electronic interchange through a health information exchange, or by access directly to an electronic health record system.

I hereby authorize the COMPANY and its reinsurers to make a brief report of my information to MIB, Inc. I understand that the COMPANY may use or disclose such information to any employee, representative, affiliate, reinsurer, independent administrator or third party for the performance of certain insurance functions including but not limited to underwriting, policy service, claims administration, and compliance; in response to subpoenas or summons; or as otherwise required or permitted by law.

I further understand that:

(1) I may refuse to sign this authorization and my refusal to sign will affect my ability to obtain life insurance coverage;

(2) Health care providers or health plans cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization;

(3) Any agreement to restrict information concerning me or any proposed insured does not apply to this authorization;

(4) Once information is disclosed under this authorization, it may be redisclosed and no longer be subject to certain state and federal laws;

(5) A copy of this authorization is as valid as the original;

(6) I may request a copy of this authorization;

(7) I may inspect or copy any information used or disclosed under this authorization;

(8) This authorization is valid from the date signed for a duration of 24 months. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the COMPANY's Service Center, Attn: Life New Business, P.O. Box 3297, Springfield, MO 65899-3297.

Name of Proposed Insured	X Signature of Proposed Insured	Date of Birth	Date

☐ Check here if you are signing as the parent, guardian or authorized representative of the proposed insured.

AGENT: EACH PROPOSED INSURED MUST SIGN A SEPARATE AUTHORIZATION.

AMERICAN NATIONAL

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

NF

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297 Business: (800) 899-6806 Fax: (888) 237-1012

MIB / FCRA PRE-NOTIFICATION

AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED(S).

MIB, Inc. Pre-Notification

Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s), however, may make a brief report of such information to the MIB, Inc. (MIB). MIB is 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 company, MIB will supply such company with information in your file upon request.

At your request, MIB will arrange disclosure of information in your file. If you question the accuracy of such information, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. MIB's telephone number is 866-692-6901 (TTY 866-346-3642), and its mailing address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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

Fair Credit Report Act Pre-Notification

We may request a consumer report, including an investigative consumer report, in connection with this application for insurance. In addition, such a report may be requested in the future to update our records or if you apply for additional coverage. The report may include information about your character, general reputation, personal characteristics or mode of living and may involve personal interviews with neighbors, friends, employers, business associates, financial sources, friends, neighbors or others with whom you are acquainted.

You have the right to request a written summary of your rights under the federal Fair Credit Reporting Act. You also have the right to make a written request within a reasonable period of time for a complete and accurate disclosure regarding the nature and scope of the requested investigation. Upon written request, we will disclose whether an investigative consumer report was requested as well as the name and address of the consumer reporting agency to whom the request was made. By contacting the agency, you may inspect and receive a copy of the report.

Conditional Receipt

NF

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

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
Business: (800) 899-6806 Fax: (888) 237-1012

* C R C T *

Policy No. _____

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

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 _____

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.

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.

AMERICAN NATIONAL®

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