Tips for Completing the Life Application

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 par**ents; 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 agent report with the client, page 10**
- **We will not accept cash payments in excess of $1,000. Cashiers checks and other similar forms of payments will be allowed.**
- **When submitting apps for large face amounts, we recommend a cover letter to explain the purpose of coverage and the financials on the file.**

Special Rider Instructions – Section 9 of the Application

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

	Type of Rider	Name of insured	Amount of insurance
☐ Other:	***Signature Term + [term of years]***	***Joe Client***	$ ***100,000***

- **If applying for more than one Signature Term Rider for multiple other insureds, must complete:**
  - Sections 2,7,12 must be completed on EACH other insured party
  - Use an additional page 3 if you have more than 2 other insured parties
  - Clarify in Sections 13-18 which other insured party the answers refer to.

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Conditional Receipts

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

Accepted Forms of Payment with the application: Cash, Check, PAC or Salary Deduction

- Conditional Receipt must be completed, signed and left with the client

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

Accepted Forms of Payment with the application: PAC or Salary Deduction

- PAC or Salary Deduction may be taken with the application
- Conditional Receipt must be completed, signed and left with the client
- NOTE: If Cash or Check is taken, it will be returned to client.

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Application for Life Insurance

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

* A P P *

1. PRIMARY PROPOSED INSURED

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

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

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

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

k. Residence address: Number/Street | City | State | ZIP

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

o. Type of business | Employer name | p. Business telephone

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

s. Business address: Number/Street | City | State | ZIP

t. U.S. Citizen: ☐ Yes ☐ No If No, type of Visa | Expiration Date

2. ADDITIONAL PROPOSED INSURED

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

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

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

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

k. Residence address: Number/Street | City | State | ZIP

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

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

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

t. Business address: Number/Street | City | State | ZIP

u. U.S. Citizen: ☐ Yes ☐ No If No, type of Visa | Expiration Date

3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

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

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

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

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

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

Name | _____ Address: Number/Street | _____

City | _____ State | _____ ZIP | _____

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

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

a. Has the name of any child age 18 or younger been omitted? ☐ Yes *(Explain.)* | _____ ☐ No

b. Is any child NOT living at the same address as the proposed insured? ☐ Yes *(Explain.)* | _____ ☐ No

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

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

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

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

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

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

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

8. PRODUCT INFORMATION

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

_____ | _____

c. Premium amount $ _____ Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ Single premium

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

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

If Participating Whole Life

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

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

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

If Indexed Universal Life

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

_____% Fixed Interest Crediting Option _____% Indexed Interest Crediting Option

If Variable Universal Life

h. Guaranteed Coverage Period: *(Elect one.)* ☐ 10-year ☐ 25-year ☐ Other _____

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

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

a. Optional benefits/riders:

☐ Premium waiver
☐ Waiver of stipulated premium $ _____
☐ Accidental death $ _____
☐ Children term $ _____
☐ Spouse term $ _____
☐ Guaranteed increase option $ _____
☐ Additional insurance option $ _____
☐ Return of Premium Rider
☐ Paid Up Additions Rider _____
Premium for PUA $ _____
☐ Premium payor *(Complete insurability application.)*
☐ Coverage continuation rider
☐ Other insured rider *(designate beneficiary below)*
☐ Level term $ _____

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

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

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

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

10. INSURANCE AND REPLACEMENTS

a. Do you have existing life insurance or annuity coverage? ☐ Yes ☐ No If yes, provide details below.
b. Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company? ☐ Yes ☐ No
If "yes", indicate which one. **Agent must provide and complete the appropriate replacement form.**
c. Total Insurance/Annuities in force on Proposed Insured(s): If none in force indicate "NONE".

Full Name of Company	Policy No.	Issue Date	Insured's Name	Plan	Amount	See "10b"

☐ Accidental Death $ _____ Company _____

11. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS $100,000 OR GREATER

Parents:	Is parent living (Y/N)	Age if living	Age at death	Cause of death
Father				
Mother				

Siblings:	Number of living	Number deceased	Age at death	Cause of death

a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? ☐ Yes ☐ No
Age at diagnosis | _____
b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma? ☐ Yes ☐ No
Type | _____ Age at diagnosis | _____

12. ADDITIONAL PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS $100,000 OR GREATER

Parents:	Is parent living (Y/N)	Age if living	Age at death	Cause of death
Father				
Mother				

Siblings:	Number of living	Number deceased	Age at death	Cause of death

a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? ☐ Yes ☐ No
Age at diagnosis | _____
b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma? ☐ Yes ☐ No
Type | _____ Age at diagnosis | _____

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13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC

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

Provider name | Date last visited | Reason for visit | HMO patient ID number

Address: Number/Street | City | State | ZIP | Provider telephone number

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

Provider name | Date last visited | Reason for visit | HMO patient ID number

Address: Number/Street | City | State | ZIP | Provider telephone number

14. MEDICAL HISTORY QUESTIONS—LIFETIME

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

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

HAS ANY PROPOSED INSURED EVER ...

b. had a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels? ☐ Yes ☐ No

c. had cancer, a tumor or abnormal growth of any kind? ☐ Yes ☐ No

d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC) excluding HIV tests? ☐ Yes ☐ No

15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

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

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

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

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

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

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

f. had arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin? ☐ Yes ☐ No

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

h. had treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? ☐ Yes ☐ No

i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed? ☐ Yes ☐ No

j. If any proposed insured(s) is less than one year old, give birth weight: | ____ lb. | ____ oz. Was birth premature? ☐ Yes ☐ No

16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS

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

a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? ☐ Yes ☐ No

b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test excluding HIV tests? ☐ Yes ☐ No

c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed? ☐ Yes ☐ No

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17. MEDICAL HISTORY EXPLANATIONS

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

Question | Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question | Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question | Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question | Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

Question | Person | Reason, condition, disease, injury, etc. | Date

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

18. INSURANCE HISTORY AND NON-MEDICAL HAZARDS

a. Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate? ☐ Yes ☐ No *(If "Yes," give details.)*

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

c. Has any proposed insured, in the past five (5) years, made — or is any proposed insured contemplating making — flights as a pilot, student pilot, crew member, or observer? ☐ Yes ☐ No *(If "Yes," complete and submit the appropriate questionnaire.)*

d. Has any proposed insured, in the past five (5) years, engaged in — or does any proposed insured intend to engage in — any hazardous avocation or sport, such as SCUBA diving, parachuting, hang-gliding, vehicle racing, or other hazardous avocation(s)? ☐ Yes ☐ No *(If "Yes," complete and submit the appropriate questionnaire.)*

e. Has any proposed insured, in the past five (5) years, been convicted of a felony? ☐ Yes ☐ No *(If "Yes," give details including county and state of conviction.)*

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

g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks? ☐ Yes ☐ No

h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks? ☐ Yes ☐ No
(If "Yes," complete and submit the Foreign Travel Questionnaire.)

Primary Proposed Insured

i. Driver's license number: | State: |

j. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years? ☐ Yes ☐ No
(if "yes", give details.) |

k. Do you have any other moving violations in the last five (5) years? ☐ Yes ☐ No
(if "yes", give details.) |

Additional Proposed Insured

l. Driver's license number: | State: |

m. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years? ☐ Yes ☐ No
(if "yes", give details.) |

n. Do you have any other moving violations in the last five (5) years? ☐ Yes ☐ No
(if "yes", give details.) |

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AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

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

I understand that:

(1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
(2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
(3) a picture copy or photocopy of this authorization shall be as valid as the original; and
(4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. I may inspect or copy any information used or disclosed under this authorization, if signed.

APPLICATION DECLARATIONS AND AGREEMENTS

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

FRAUD STATEMENT

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

FCRA / MIB ACKNOWLEDGEMENT

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

APPLICATION SIGNATURES

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

For Indexed Universal Life:

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

For Variable Universal Life:

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

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

Witnessed by: Signature of licensed agent

X _____

Print agent's name

_____

Agent's state license number

_____

Agent's company personal code

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

X _____

Signature of additional person(s) proposed for insurance

X _____

Signature of additional person(s) proposed for insurance

X _____

Signature of owner if other than proposed insured

X _____

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* A G R *

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

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

Dated at: City | Month/Day/Year

_____ | _____

Corporation name | Tax ID | Social Security number

_____ | _____ | _____

Branch office number and PSO code | Agent personal code or number | CSSD District Code 2 | Agency #

_____ | _____ | _____ | _____

Licensed agent's signature | Agent e-mail | Telephone number

X _____ | _____ | (_____) _____

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

If prior quote was reviewed, please provide quote number: | _____

Additional policy plan and amount

_____ $ _____

Alternate policy plan and amount

_____ $ _____

Are commissions to be split? ☐ Yes ☐ No *(If "Yes," and split 50/50, list both agents' names and personal code number. If NOT, complete and submit Form 6151.)*

Agent name | Personal code or number | Agent name | Personal code or number

_____ | _____ | _____ | _____

Special Instructions: | _____

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:

Oral fluid test collected by agent ☐ Yes ☐ No Date collected? | _____ ☐ Lab ticket attached or affix barcode here: _____

Inspection ordered ☐ Yes ☐ No *(If "Yes," give name of inspection service used.)*

_____

☐ Exam by physician, full blood, HOS ☐ EKG ☐ X-ray ☐ Paramed, full blood, HOS ☐ Full blood, physical measurements, HOS

☐ Paramed, HOS | _____ ☐ Other | _____

Name of approved paramed company? | _____

Were medical records (APS) ordered by producer? ☐ Yes ☐ No (If "Yes," give physician/clinic name)

_____

Did you pay for the attending physician's statement? ☐ Yes ☐ No

(If "Yes," enter check # | _____ *and amount* $ _____*)*

Has the application been reviewed for omissions and errors? ☐ Yes ☐ No

If "yes", by (name) _____

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22. NUMBER OF APPLICATIONS

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

(If "Yes," give the serial number on the other application(s).

_____ | _____

23. NOTES TO UNDERWRITER

_____

_____

_____

_____

24. BILLING DATA

a. Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ Single premium

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

Name

| _____

Number/Street City

| _____ | _____

State ZIP Country

| _____ | _____ | _____

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

☐ MDO

☐ Salary deduction: Name Number

| _____ | _____

☐ Biweekly Amount | _____

☐ Government allotment: Payee name

| _____

☐ A. Copy of certified allotment attached to application

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

☐ C. Cash with application — No allotment copy

☐ D. C.O.D. — Defer issue until allotment begins.

Rank | _____ Branch | _____ Social Security number | _____

Special dating instructions: Issue age | _____ Issue date | _____

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

Name of premium payor who will pay premium Social Security number

_____ | _____

Name(s) of insured(s)

_____

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

_____ | _____

Bank name Branch name Bank transit number

_____ | _____ | _____

Bank address: Number/Street City State ZIP

_____ | _____ | _____ | _____

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

Date: Month/Day/Year Signature of premium payer

_____ **X** _____

Agent

X _____

AMERICAN NATIONAL

* C R C T *

CONDITIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

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

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

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

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

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

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

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

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

_____ | _____ | _____ | _____

Signature of licensed agent

X _____

I have read this conditional receipt. It has been explained to me by the agent.

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

X _____

Signature of Owner

X _____

AMERICAN NATIONAL

* M I B *

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

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

Thank you for considering American National Insurance Company as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

MIB Pre-notification — Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree, Suite 400, Braintree, MA 02184-8734.

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

Fair Credit Reporting Act Pre-notification — Federal and state laws require notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or, for the appropriate fee, receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.

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

* E L D E R *

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

Agent's Full Name:

_____

(As it appears on California insurance license)

Agent's License Number: _____

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

_____

_____

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

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

_____

(Print name)

_____ _____

(Signature) ***Date***

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

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)

* E L D E R A *

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

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

_____ _____
Agent's Signature **Date**

_____ _____
Owner Signature **Date**

Notice Regarding Standards for Medi-Cal Eligibility and Recovery

For Distribution by Insurers, Agents, and Brokers

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)

* E L D E R *

State of California—Health and Human Services Agency

Department of Health Care Services

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

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

Recovery

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

Unmarried Resident

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

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

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $115,920 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $2,898 in monthly income, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $115,920 in countable resources. The order also may allow the at-home spouse to retain more than $2,898 in monthly income.

Real and Personal Property Exemptions

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

Real Property Exemptions

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

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

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

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

Personal Property and Other Exempt Assets

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

There may be other assets that may be exempt.

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

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

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

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

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

X Purchaser signature _____ Date _____

X Spouse's signature _____ Date _____

X Legal representative signature _____ Date _____

DHCS 7102 (01/13)

NOTICE AND CONSENT FOR
BLOOD OR OTHER BODY FLUID TESTING WHICH MAY INCLUDE AIDS RELATED TESTING

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

PRE-TESTING CONSIDERATIONS

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

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

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

CONFIDENTIALITY OF TEST RESULTS

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

AMERICAN NATIONAL

NOTIFICATION OF TEST RESULT

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

NAME AND ADDRESS OF PHYSICIAN FOR REPORTING A POSSIBLE POSITIVE TEST RESULT:

_____

_____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: _____.The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

_____

_____

The result will be sent to that person by registered mail with restricted delivery.

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Testing. I voluntarily consent to the collection of blood, oral fluid from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____

Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

_____

Name of Proposed Insured

_____

Address

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

IMPORTANT NOTICE OF PRIVACY POLICY And INFORMATION PRACTICES

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

Information We Collect

The personal data about you we obtain may include:

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

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

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

How We Use and Disclose Personal Data

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

Disclosures we may legally make include:

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

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

Examples of functions that require access to personal data include:

- Underwriting and policy service
- Claims processing
- Reinsurance

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

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

Your Right To Review and Correct Personal Data

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

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

Notice Regarding Replacement

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

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

* I R F *

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

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

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

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

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

_____ _____

(Applicant's Signature) (Date)

_____ _____

(Agent's Signature) (Date)

Pre-Authorized Payment Plan - Authorization Form

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)

* P A C *

Bank Account Information:

The undersigned account holder requests that policy premiums specified below be paid by electronic debit by the bank named in this request. If at any time funds in my account are insufficient to pay these debits, the pre-authorized payment privilege will 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. I understand and agree that all debits are accepted by the Company subject to their being honored upon presentation.

Transit Number | **Account Number**

☐ Checking
☐ Savings

Print Name of Bank Account Holder _____

Signature of Bank Account Holder _____

Signature of Joint Bank Account Holder _____

Bank _____ **Branch** _____

Street Address _____

City _____ **State** _____ **ZIP** _____

Policy Information:

Policy Number	Requested Withdrawal Date	Paid to Date

❑ **I authorize American National Insurance Company to debit my account for premiums necessary to pay my policy current.**

❑ **I authorize American National Insurance Company to deduct $ _____ monthly for my loan indebtedness. (minimum $15.00)**

Insured Name _____ **Date** _____

Owner/Controller Name _____ **Owner/Controller Signature** _____

Joint Owner Name _____ **Joint Owner Signature** _____

PLEASE ATTACH A "VOID" SPECIMEN OF CHECK IN THE SPACE PROVIDED.

USE ADHESIVE TAPE

DO NOT STAPLE OR GLUE

ENSURE THAT ALL EDGES ARE TAPED SECURELY BEFORE SCANNING