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 15 years and 6 months or younger. 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 licensed 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: _____

- Reckless Driving ..... ☐ 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: _____

- Reckless Driving..... ☐ 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. Acquired Immune Deficiency Syndrome (AIDS)

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

Has any proposed insured **EVER** been diagnosed by a licensed member of the medical profession with an Immune Deficiency Disorder (other than HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)? ..... ☐ 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 licensed 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 HIV (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 licensed 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 licensed 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

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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. Any history of 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. Any history of 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. Any history of 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. Any history of 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. Any history of 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. Any history of 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 submits an application for insurance containing materially false information or conceals information for the purpose of misleading is committing insurance fraud, which is a crime and may subject that person to criminal and civil penalties.

Application Signatures

By signing this application I agree to the following:

- I have read the application and all statements and answers that I have provided are true and complete.
- The statements and answers in this application were made to induce the Company to issue a policy, and are the basis for and will become part of any policy issued on this application. Information about any person in the application must be provided in the application or an amendment to the application, or else it will not be considered to have been provided to American National Insurance Company.
- 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 must notify American National Insurance Company. No policy will be effective until: (1) it is delivered to the applicant, and to the best of the applicant's knowledge or belief, he/she is in the same health as stated on the application, and (2) the full first premium has been paid during the lifetime of the insured.
- 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;
- American National Insurance Company may issue a policy different than requested in this application, but 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 or change any provisions of this application.
- If a premium payment was submitted with the application: (1) American National Insurance Company's maximum amount of liability with respect to any temporary insurance created by California statute is $50,000; (2) I have received and read the Premium Receipt and agree to its terms and I understand that any agreement creating temporary insurance is governed by the Premium Receipt and not by this application; and (3) I understand that the death benefit is limited to a total of $50,000 for all proposed insureds named in this application prior to either my application being approved for issuance or being declined.
- 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 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

F

* 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.

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 _____

AMERICAN NATIONAL

Authorization to Release, Obtain and Disclose Information

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

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;
- AIDS or ARC treatment related information;
- 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.

_____	X_____	_____	_____
Name of Proposed Insured	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.

Premium Receipt

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

F

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.
PAY THE FULL INITIAL PREMIUM BASED ON THE MODE OF PREMIUM CHOSEN.

For purposes of this receipt, "the Company" refers to American National Insurance Company.

Coverage. The maximum amount of death benefit on all the proposed insureds named in your application is **$50,000**, regardless of the amount requested in the application. If a claim is made under this Receipt any premium paid in excess of the premium required for a $50,000 death benefit will be refunded with the death benefit payment. The death benefit will be paid to the beneficiary(ies) named in the application. The Company's obligation to pay is subject to the same rights, conditions and defenses as if the policy had been issued and delivered on the date of application.

Termination. Coverage under this Premium Receipt will end on the earlier of:

(1) The date the application is approved for issuance; or

(2) The date the Company mails the premium refund and notice that the application has been declined.

Void. This Premium Receipt is void and any premium received will be returned, if:

(1) The check or authorized payment is not honored when presented for payment;

(2) The proposed insured commits suicide;

(3) The application contains any material misrepresentation; or

(4) This Premium Receipt has been altered or modified.

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

_____ | _____ | _____ | _____

I have read this Premium Receipt and agree to its terms. I understand that $50,000 is the maximum amount of coverage under this Premium Receipt, regardless of the amount of insurance requested.

Signature of Proposed Owner

X _____

AGENT STATEMENT

Amount Remitted: $ _____ Payor Name: _____

I have received the amount indicated above in connection with an application for life insurance bearing the same serial number as this receipt.

Signature of Licensed Agent

X _____

Date: Month/Day/Year

_____

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

R

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

ELDERA

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

R

For Distribution by Insurers, Agents, and Brokers

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* 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, also may 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 $126,420 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 $3,161 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 $126,420 in countable resources. The order also may allow the at-home spouse to retain more than $3,161 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 Owner's signature	Date
X Spouse's signature	Date
X Legal representative signature	Date

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)

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

F

* 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.

AMERICAN NATIONAL

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

NF

* 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***

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

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* H I V *

READ THIS NOTICE VERY CAREFULLY

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

AIDS:

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

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

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

The symptoms of AIDS may include the following:

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

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

PRE-TESTING CONSIDERATIONS

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

MEANING OF POSITIVE TEST RESULT

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

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

AMERICAN NATIONAL

PART A - (continued)

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

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

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

CONFIDENTIALITY OF TEST RESULTS

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

NOTIFICATION OF TEST RESULTS

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

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

F

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

☐ American National Insurance Company
☐ American National Life Insurance Company of Texas

* H I V *

Read this notice very carefully.
Do not sign it unless it is completely filled out and you have read and understood it.

I have received, read, and understand the Notice and Consent For Human Immunodeficiency Virus/AIDS-Related Testing ("Part A"). I voluntarily consent to the collection/withdrawal of blood, oral fluid from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described in Part A. I have read and understand the information provided to me about what a positive test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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

Examiner _____ Insurer _____

Address _____ Address _____

_____ _____

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

Physician's Name _____

Physician's Address _____

If you want to know the results of the test but do not at present have a private physician, the result will be sent to you at the address provided below. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

Name _____

Address _____

_____

_____

_____
Proposed Insured Printed Name

_____|_____
Proposed Insured or Parent/Guardian-Signature Date

_____|_____
Parent/Guardian-Printed Name (if applicable) Date

Supplement Application for Accelerated Benefit Riders (Critical)

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

F

CRABRSUP

Proposed Insured's Name | Date of Birth | Policy Number

GENERAL DETAILS OF OTHER COVERAGE AND REPLACEMENTS

1. Is the applicant currently covered by comprehensive health benefits from an individual or group health policy or an HMO or employer plan providing essential health benefits? ❑ Yes ❑ No
   NOTICE: An applicant that is not covered by comprehensive health coverage is not eligible for this product.

MEDICAL QUESTIONS

Has a member of the medical profession ever diagnosed the Proposed Insured with or treated the Proposed Insured For:

1. Memory Loss?	❑ Yes	❑ No	15. Multiple Myeloma?	❑ Yes	❑ No
2. Paralysis?	❑ Yes	❑ No	16. Amputation due to disease?	❑ Yes	❑ No
3. Stroke?	❑ Yes	❑ No	17. Heart Disease or Disorder?	❑ Yes	❑ No
4. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	❑ Yes	❑ No	18. Liver Disease?	❑ Yes	❑ No
			19. Diabetes?	❑ Yes	❑ No
5. Parkinson's Disease?	❑ Yes	❑ No	20. Connective Tissue Disorder?	❑ Yes	❑ No
6. Multiple Sclerosis?	❑ Yes	❑ No	21. Joint Replacement?	❑ Yes	❑ No
7. Muscular Dystrophy?	❑ Yes	❑ No	22. Back Surgery?	❑ Yes	❑ No
8. Myasthenia Gravis?	❑ Yes	❑ No	23. Cancer (excluding Basal Cell Skin Cancer)	❑ Yes	❑ No
9. Huntington's Chorea?	❑ Yes	❑ No	24. Organ Transplant?	❑ Yes	❑ No
10. Emphysema?	❑ Yes	❑ No	25. Substance Abuse?	❑ Yes	❑ No
11. Chronic Obstructive Pulmonary Disease?	❑ Yes	❑ No	26. Hypertension (Systolic BP > 200 and/or Diastolic BP > 110)	❑ Yes	❑ No
12. Chronic pain currently requiring treatment with narcotic medication or medicinal marijuana?	❑ Yes	❑ No	27. Disease of the eye other than that corrected solely by glasses or contacts?	❑ Yes	❑ No
13. Kidney Disease?	❑ Yes	❑ No			
14. Cystic Fibrosis?	❑ Yes	❑ No	28. Aneurysms or other diseases of the arteries?	❑ Yes	❑ No

NOTICE

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

DECLARATION OF AGREEMENT AND SIGNATURES

I understand that AMERICAN NATIONAL INSURANCE COMPANY may use other medical information that it obtains about me that I have authorized them to obtain for medical underwriting purposes. That information may be from a 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, or a paramedical facility.

I understand and agree that all answers given above are to the best of my knowledge and belief complete and true. This application shall be part of any contract issued.

Applicant *(Sign name in full)* _____ Date _____

Proposed Insured *(If other than the Applicant, sign name in full)* _____ Date _____

Agent *(Sign name in full)* _____ Date _____

Premium Receipt

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

F

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.
PAY THE FULL INITIAL PREMIUM BASED ON THE MODE OF PREMIUM CHOSEN.

For purposes of this receipt, "the Company" refers to American National Insurance Company.

Coverage. The maximum amount of death benefit on all the proposed insureds named in your application is **$50,000**, regardless of the amount requested in the application. If a claim is made under this Receipt any premium paid in excess of the premium required for a $50,000 death benefit will be refunded with the death benefit payment. The death benefit will be paid to the beneficiary(ies) named in the application. The Company's obligation to pay is subject to the same rights, conditions and defenses as if the policy had been issued and delivered on the date of application.

Termination. Coverage under this Premium Receipt will end on the earlier of:

(1) The date the application is approved for issuance; or

(2) The date the Company mails the premium refund and notice that the application has been declined.

Void. This Premium Receipt is void and any premium received will be returned, if:

(1) The check or authorized payment is not honored when presented for payment;

(2) The proposed insured commits suicide;

(3) The application contains any material misrepresentation; or

(4) This Premium Receipt has been altered or modified.

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

_____ | _____ | _____ | _____

I have read this Premium Receipt and agree to its terms. I understand that $50,000 is the maximum amount of coverage under this Premium Receipt, regardless of the amount of insurance requested.

Signature of Proposed Owner

X _____

AGENT STATEMENT

Amount Remitted: $ _____ Payor Name: _____

I have received the amount indicated above in connection with an application for life insurance bearing the same serial number as this receipt.

Signature of Licensed Agent

X _____

Date: Month/Day/Year

_____