Application for Life Insurance

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

F

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 premiums):*

Name | _____ Address: Number/Street | _____

City | _____ State | _____ ZIP | _____

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

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

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

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

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

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

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

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

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

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

8. PRODUCT INFORMATION

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

_____ | _____

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

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

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

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

If Participating Whole Life

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

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

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

If Indexed Universal Life

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

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

If Variable Universal Life

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

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

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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 BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR ...

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

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

d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? ☐ Yes ☐ No

15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

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

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

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

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

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

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

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

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

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

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

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

16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS

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

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

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

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

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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 mountain climbing, rock climbing, racing, SCUBA diving, hang-gliding, balllooning or skydiving? ☐ Yes ☐ No *(If "Yes," complete and submit the appropriate questionnaire.)*

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

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

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

FRAUD STATEMENT

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

FCRA / MIB ACKNOWLEDGEMENT

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

APPLICATION SIGNATURES

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

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

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

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

Witnessed by: Signature of licensed agent

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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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

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

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

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

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.

USA Patriot Act Notification and Customer Identification Verification

NF

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

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

* U S A *

1. Client Name _____ **Application or Policy Number** _____

Source of Funds ☐ W-2 Wages ☐ Investments ☐ Social Security or Pension ☐ Savings ☐ another insurance contract
☐ Other (please explain) _____

USA PATRIOT Act Notice – *to be read by or to customer.*

2. The USA PATRIOT Act requires that we establish an Anti-Money Laundering ("AML") Program, notify customers that we must verify the identity of the owner(s) of our contracts, and collect documents and information sufficient to provide such verification. You should know that failure to provide the requested identification will result in delays in the issuance of the requested coverage and may result in a decision not to accept your business.

Customer Identification Verification In order to satisfy such obligations, we require our representative to review and verify a current government issued photo ID for each Owner/Trustee/Partner associated with a contract. Information on such identification must be recorded below. We may use third party sources to verify the information provided.

a. **Identification Verified** (One for each Owner/Trustee/Partner. Use additional forms if necessary.)

Owner/Trustee/Partner
Check one form of ID:
☐ Driver's license
☐ Resident Alien ID (Green Card)
☐ Passport
☐ Other: (Describe) _____

Joint Owner/Trustee/Partner
Check one form of ID:
☐ Driver's license
☐ Resident Alien ID (Green Card)
☐ Passport
☐ Other: (Describe) _____

The following information should be recorded exactly as it appears on the identification reviewed

Name _____ Date of Birth _____
Street Address (not PO Box) _____
City, State, Zip _____
Number on ID _____ State or Country _____
Identification Expiration Date _____

Name _____ Date of Birth _____
Street Address (not PO Box) _____
City, State, Zip _____
Number on ID _____ State or Country _____
Identification Expiration Date _____

b. Entity Verification: Check the appropriate entity as listed below and submit copies of documentation viewed to gain first-hand knowledge of the existence of a legitimate business. If the Owner is a minor or non-legal entity, review the identification of the individual who submits an application on behalf of the minor or non-legal entity.

☐ **Corporation, LLC, professional association, or professional corporation:** Articles of Incorporation, Organization or Association or similar document filed in the state in which the entity is formed
☐ **Limited Partnership:** Certificate of Limited Partnership or similar document filed in the state where the partnership is formed
☐ **General Partnership or Joint Venture:** Agreement, Joint Venture Agreement or similar agreement governing the formation and operation of the partnership
☐ **Trust and All Other Entities:** Document governing the formation and operation of the entity

3.
☐ I certify that I personally met with the proposed Owner(s)/Trustee(s)/Partners and reviewed the above identification document. To the best of my knowledge, it accurately reflects the identity of the proposed Owner(s)/Trustee(s)/Partners.
☐ I was unable to personally review the identification documents for the reason stated below. I certify that, to the best of my knowledge, the information provided by the Owner(s)/Trustee(s)/Partners is true and accurate.

Reason for not reviewing documents _____

Note: Failure to personally review the identification documents will result in processing delays in order to verify customer identity and may result in a decision not to accept the business.

Representative Name _____ Personal Code _____

Representative Signature _____ Date _____

Certification and Acknowledgement of Computer Screen Illustration

NF

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* I L A *

Please complete and sign *either* Section A *or* Section B.

A. Certification and Acknowledgment of Computer Screen Illustration

I acknowledge that I viewed a computer screen illustration and that no hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

Applicant's Signature _____ Date _____

I certify that I displayed a computer screen illustration for _____ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

Gender: Male _____ Female _____; Age: _____

Underwriting or Rating Class: _____

Type of Policy: _____

Initial Death Benefit: $ _____

Dividend Option (if applicable): _____

Agent's Signature _____ Date _____

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B. Acknowledgment That No Illustration Was Provided

I acknowledge that I have not received an illustration that matches the policy I am applying for. I further acknowledge that an illustration conforming to the policy as issued will be provided to me to sign no later than at the time of delivery.

Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____

Important Notice: Replacement of Life Insurance or Annuities

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

* I R F *

Do you have existing insurance or annuity coverage?

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

Applicant's Signature	Date	Producer's Signature	Date

☐ Yes; please continue.

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

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

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

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

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

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

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

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

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

Applicant's Signature	Date

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

	INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

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

SPECIFIC REASON FOR REPLACING EXISTING POLICY WITH NEW PROPOSED POLICY:

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

Remember, where a replacement is involved, the policy owner has the right to return the policy within thirty (30) days of delivery of the contract and receive a full refund of all premiums.

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

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PREMIUMS:

Are they affordable?

Could they change?

Are they guaranteed on your current policy?

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

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

POLICY VALUES:

Does your current policy pay dividends?

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

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

What surrender charges do the policies have?

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

Does the new policy provide more insurance coverage?

INSURABILITY:

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

You may need a medical exam for a new policy.

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

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

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

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

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

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

Will you pay surrender charges on your old contract?

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

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

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

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

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

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

Statement of Policy Regarding Replacements

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

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

Producer's Signature _____ Date _____

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

I acknowledge that the responses herein are, to the best of my knowledge, accurate (see above statement).

Applicant's Signature _____ Date _____ Producer's Signature _____ Date _____

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

PART A - NOTICE AND CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS/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

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:

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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

Prepared by the National Association of Insurance Commissioners

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

This guide does not endorse any company or policy.

Reprinted By:

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

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

Important Things to Consider

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

Buying Life Insurance

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

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

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

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

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

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

What About the Policy You Have Now?

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

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

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

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How Much Do You Need?

Here are some questions to ask yourself:

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

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

What is the Right Kind of Life Insurance?

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

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

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

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

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

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

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

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

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

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

Life Insurance Illustrations

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

Finding a Good Value in Life Insurance

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

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

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

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