Application for Individual Life Insurance Policy

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

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297
Business: (877) 862-0759 Fax: (888) 237-1012

* A P P *

1. 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. Height Weight i. Occupation

j. Has the Proposed Insured used tobacco or nicotine in the past 12 months? ☐ Yes ☐ No

k. Resident Address: Number/Street City State ZIP

l. Phone Number: Home Cell m. E-mail Address

2. Ownership *(if other than Proposed Insured)*

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

c. Gender: ☐ Male ☐ Female d. Date of Birth: Month/Day/Year e. Age f. Social Security/Tax ID Number g. If Trust, Date Created

h. Mailing Address: Number/Street City State ZIP

i. Phone Number j. E-mail Address

k. Contingent Owner Name (*if any*): Last First M.I. l. Relationship of the Contingent Owner (*if any*) to Proposed Insured

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

a. Name: Last First M.I.

b. Resident Address: Number/Street City State ZIP

4. 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.)*

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

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

g. Resident Address: Number/Street City State ZIP

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

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

g. Resident Address: Number/Street City State ZIP

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

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

g. Resident Address: Number/Street City State ZIP

5. 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 Proposed Insured

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

g. Resident Address: Number/Street City State ZIP

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

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

g. Resident Address: Number/Street City State ZIP

6. Other Insurance and Replacements

a. Do you have any existing life insurance or annuity coverage?.......... ☐ Yes ☐ No

If Yes, list existing coverages: ____

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?..... ☐ Yes ☐ No

7. Medical History

Part 1: The Proposed Insured is not eligible for life insurance if any question in Part 1 is answered **Yes**.
If all questions are answered **No**, proceed to Part 2.

1. Has the Proposed Insured **EVER** been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
2. In the **last 2 years**, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: a heart attack, stroke, cirrhosis of the liver; or cancer (other than non-melanoma skin cancer)? ☐ Yes ☐ No
3. Is the Proposed Insured currently hospitalized, confined to a bed, in a nursing home or hospice? ☐ Yes ☐ No

Part 2: The Proposed Insured is only eligible for a modified death benefit if any question in Part 2 is answered **Yes**.
If all questions are answered **No**, proceed to Part 3.

4. **In the past 5 YEARS, has the Proposed Insured been diagnosed, treated, or consulted with a member of the medical profession for:**
   a. an organ transplant, or been on a waiting list for an organ transplant? ☐ Yes ☐ No
   b. renal failure or received kidney dialysis? ☐ Yes ☐ No
   c. heart valve replacement, implanted defibrillator, cardiomyopathy, congestive heart failure, or aneurysm? ☐ Yes ☐ No
   d. Alzheimers, dementia? ☐ Yes ☐ No
   e. Chronic Hepatitis B or C? ☐ Yes ☐ No
   f. leukemia or lymphoma (Hodgkins or non-Hodgkins), cancer (other than basal cell skin cancer), or malignant melanoma? ☐ Yes ☐ No
   g. stroke, Cerebral Vascular Accident (CVA), or Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
   h. Alcohol or Drug Abuse? ☐ Yes ☐ No
   i. tested positive for human immunodeficiency virus (HIV)? ☐ Yes ☐ No
5. In the **past 2 years**, has the Proposed Insured had any of the following: coronary angioplasty, coronary artery bypass surgery, or coronary artery stenting? ☐ Yes ☐ No

Part 3: The Proposed Insured may require graded death benefit if 1 of the following questions is answered **Yes**.
The Proposed Insured may require modified death benefit if 2 or more questions are answered **Yes**.
If all questions are answered **No**, Proposed Insured may qualify for level death benefit.

6. **In the past 2 YEARS, has the Proposed Insured been diagnosed, treated, or consulted with a member of the medical profession for:**
   a. Chronic Obstructive Pulmonary Disease (COPD) or emphysema? ☐ Yes ☐ No
   b. complications from diabetes (including vision problems, kidney problems, nerve problems, numbness, or amputations as a result of diabetes)? ☐ Yes ☐ No
   c. diabetes requiring insulin? ☐ Yes ☐ No
   d. a psychiatric condition requiring hospitalizations or extended in-patient care? ☐ Yes ☐ No
   e. Multiple Sclerosis or Parkinson Disease? ☐ Yes ☐ No
   f. Crohn's disease or ulcerative colitis? ☐ Yes ☐ No
   g. atrial fibrillation? ☐ Yes ☐ No
7. In the **past 2-5 years**, has the Proposed Insured been diagnosed, treated, or consulted with a member of the medical profession for any of the following: heart attack, coronary artery bypass, coronary artery angioplasty, or coronary artery stenting? ☐ Yes ☐ No

8. Product Information

a. Plan Type: ☐ Level Death Benefit ☐ Graded Death Benefit ☐ Modified Death Benefit

b. Face Amount _____ c. Initial Premium Payment _____

AMERICAN NATIONAL

* D E C L *

Fraud Statement

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

Application 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 complete and true to the best of their knowledge and belief. They also agree that:

- these answers as written: a) were given to induce American National Life Insurance Company of Texas to issue a Policy; and b) shall form the basis for and become part of any Policy issued on the application;
- except as otherwise provided in the conditional or premium receipt no Policy will be effective until it is: a) issued; b) delivered to the Applicant; c) the full first premium paid, all during the lifetime and good health of the insured(s);
- the Company may issue a policy different from that specified in this application subject to my approval and acceptance, 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;
- American National Life Insurance Company of Texas is not bound by any statements made by anyone or any other facts known to anyone concerning the Proposed Insured if not in writing in this application or any supplement to it; and
- only the President, a Vice President, or the Secretary of American National Life Insurance Company of Texas has the authority to waive any of American National Life Insurance Company of Texas' rights or requirements or to waive or alter any of the provisions of this application or the Policy issued on this application.

I have received the notification regarding the Federal Fair Credit Report Act and the MIB, Inc.

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 Proposed Insured

X _____

Signature of Owner (if other than Proposed Insured)

X _____

Agent's Report

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* A G R *

1. Agent's Statement

I certify that I asked the Proposed Insured the questions in the application and recorded the answers. The answers recorded did not conflict with my observations and knowledge of the Proposed Insured.

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

Agent's Social Security Number _____ Agent's Company Personal Code _____ Agent's Phone Number _____

Agent's E-mail Address _____

Signature of Licensed Agent

x _____

2. Agent's Supplement

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

b. How long have you personally known the Proposed Insured?..... _____ Years _____ Months

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

(If Other, explain.) _____

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

3. Agent's Report

a. During the interview, did you observe if the Proposed Insured had any physical or mental impairment with regard to walking, speaking, or clearly understanding questions on the application?..... ☐ Yes ☐ No

Be sure to inform your client that a telephone interview may be conducted.

b. The best time(s) to call for a telephone interview:

_____

_____

_____

c. If the Proposed Insured has a hearing problem, describe.

_____

_____

_____

4. Additional Agent Instructions

_____

_____

_____

5. Notes to Underwriter

_____

_____

_____

Billing Information

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* P A C *

1. Billing Data

a. Premium Billing Mode (select one):

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly

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

_____

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

Name of Premium Payer

_____

Name of Proposed Insured

_____

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 Life Insurance Company of 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 Licensed Agent

X _____

Authorization to Release, Obtain and Disclose Information

NF

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* H I P A *

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 American National Life Insurance Company of Texas, or any employee, representative, affiliate, reinsurer, independent administrator or third party acting on American National Life Insurance Company of Texas' behalf, any and all information concerning me or any proposed insured, to the extent permitted by state and federal law, including but not limited to:

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

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

I hereby authorize American National Life Insurance Company of Texas and its reinsurers to make a brief report of my information to MIB, Inc. I understand that American National Life Insurance Company of Texas 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 American National Life Insurance Company of Texas' Service Center, Attn: Life New Business, P.O. Box 3297, Springfield, MO 65899-3297.

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

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

AGENT: EACH PROPOSED INSURED MUST SIGN A SEPARATE AUTHORIZATION.

Mailing Address: Mail Processing Center, P.O. Box 3297, Springfield, MO 65808-3297
Phone Number: (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 Life Insurance Company of Texas 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 Life Insurance Company of Texas or its reinsurer(s) may also release information in your file to other insurance companies to whom you apply for life or health insurance coverage or to whom a claim for benefits is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Report Act Pre-Notification

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

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

Conditional Receipt

NF

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* C R C T *

Policy No. _____

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS.
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 $50,000.

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

X _____

Signature of Owner

X _____