

SERFF Tracking Number: AMNA-125909789 State: Arkansas  
Filing Company: American National Insurance Company State Tracking Number: 41037  
Company Tracking Number: 4165  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 4165  
Project Name/Number: 4165/

## Filing at a Glance

Company: American National Insurance Company

Product Name: 4165

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMNA-125909789 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: 4165

Co Status:

Author: Tracey Johnfroe

Date Submitted: 12/05/2008

State Tr Num: 41037

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/10/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: 4165

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/10/2008

State Status Changed: 12/10/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Form 4165 is a supplemental application used to gather financial information about the applicant and will be used with all life products which have a face amount ranging from two-million dollar to ten million dollars to asses the financial need in relation to amount applied for. This form is used at an underwriter's discretion if supporting documentation for financial information on such cases is not provided or incomplete, and could possibly be used on smaller face amounts, but not likely for any amount less than one million dollars.

## Company and Contact

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**Filing Contact Information**

Tracey Johnfroe, Life Policy Analyst Tracey.Johnfroe@ANICO.com  
 One Moody Plaza (409) 463-4661 [Phone]  
 Galveston, TX 77550 (709) 766-6933[FAX]

**Filing Company Information**

American National Insurance Company CoCode: 60739 State of Domicile: Texas  
 One Moody Plaza Group Code: 408 Company Type:  
 Galveston, TX 77550 Group Name: State ID Number:  
 (409) 763-4661 ext. [Phone] FEIN Number: 74-0484030  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	\$50.00	12/05/2008	24365115

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	12/10/2008	12/10/2008

*SERFF Tracking Number:* AMNA-125909789      *State:* Arkansas  
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*Project Name/Number:* 4165/

## **Disposition**

Disposition Date: 12/10/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* AMNA-125909789      *State:* Arkansas  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Statement of Variability		Yes
<b>Supporting Document</b>	Cover Letter		Yes
<b>Form</b>	Application:Financial Statement Supplement		Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 4165-AR	Application/Enrollment Form	Application:Financial Initial Statement Supplement	Initial		52	Form 4165-AR.pdf



# Application: Financial Statement Supplement

American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



## Name of Proposed Insured \_\_\_\_\_

The following financial disclosures are made for the purpose of establishing insurability, for the amount of life insurance I have applied for on my life. They are furnished as a true and accurate statement of my current financial condition.

ASSETS		LIABILITIES	
Cash in banks	\$	Notes payable to banks	\$
Notes receivable	\$	Notes payable to others	\$
Accounts receivable	\$	Accounts payable	\$
Cash values life insurance	\$	Loans on life insurance	\$
Real estate	\$	Taxes and interest due	\$
Business interest (net of all liabilities)	\$	Mortgages or liens on real estate	\$
Stocks and bonds (not included above)	\$	I.R.S. liens	\$
Personal property (auto, furniture, etc.)	\$	Contingent liabilities	\$
Other assets (describe)	\$	Other liabilities (describe)	\$
<b>Total Assets</b>	<b>\$</b>	<b>Total Liabilities</b>	<b>\$</b>
		<b>Total Net Worth (Assets-Liabilities)</b>	<b>\$</b>

### INCOME

### CURRENT CALENDAR YEAR

### LAST CALENDAR YEAR

### CALENDAR YEAR PRIOR

Gross annual salary	_____	_____	_____
Dividends, etc.	_____	_____	_____
Other income (describe)	_____	_____	_____
Total	_____	_____	_____

Are there any law suits pending or judgments against you at this time? .....  Yes  No

If yes, please provide details? \_\_\_\_\_

\_\_\_\_\_

Have you ever filed for bankruptcy? .....  Yes  No

If yes, when? \_\_\_\_\_

Additional Remarks

\_\_\_\_\_

\_\_\_\_\_

I understand that this form will be a part of the application and that the accuracy of the information I have provided herein will be relied upon by the Company in determining whether to accept my application for life insurance.

**Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Proposed Insured \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

<i>SERFF Tracking Number:</i>	<i>AMNA-125909789</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American National Insurance Company</i>	<i>State Tracking Number:</i>	<i>41037</i>
<i>Company Tracking Number:</i>	<i>4165</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>4165</i>		
<i>Project Name/Number:</i>	<i>4165/</i>		

## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice 11/18/2008

**Comments:**

Find attached the Flesch Certification titled AR - Certification of Compliance

**Attachment:**

AR - CERTIFICATION OF COMPLIANCE.pdf

### Review Status:

**Satisfied -Name:** Application 11/18/2008

**Comments:**

Application 9927 is used with this Finanacial Statement Supplement

**Attachment:**

COPY OF APPROVED APPLICATION 9927.pdf

### Review Status:

**Satisfied -Name:** Statement of Variability 12/03/2008

**Comments:**

**Attachment:**

SOV - STATEMENT OF VARIABILITY.pdf

### Review Status:

**Satisfied -Name:** Cover Letter 12/04/2008

**Comments:**

**Attachment:**

AR - 20081203.pdf



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## ARKANSAS

### CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19

ACA 23-80-206 (Flesch Certification, minimum of 40) – Form 4165 achieves a score of 52.2

<u>Form</u>	<u>Form Name</u>	<u>Scoring(s)</u>
Form 4165-AR	Application: Financial Statement Supplement	52.2

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Rex D. Hemme  
Vice President & Actuary  
American National Insurance Company



1. PROPOSED INSURED			b. Birth State/Birth Place		c. Age	d. Sex	e. Marital Status: <input type="checkbox"/> Mar. <input type="checkbox"/> Sep. <input type="checkbox"/> Sing. <input type="checkbox"/> Wid. <input type="checkbox"/> Div.		
a. Last Name	First Name	M.I.							
f. Date of Birth Mo./Day/Yr.	g. Height and Weight	h. Social Security Tax ID No.		i. Has proposed insured used tobacco in any form during the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
j. Residence Address No. & Street _____			k. County _____		l. Home Phone ( _____ ) _____		n. Former Address (Past 2 yrs.)		
City, State _____ ZIP _____					m. How long at this address _____				
o. Occupation - Job title/duties (Be specific)				p. Employed by and kind of business					
q. Business Address No. & Street _____ City /State _____ ZIP _____				r. Phone ( _____ ) _____		s. Date of employment Month _____ Year _____			
2. ADDITIONAL PERSON PROPOSED FOR INSURANCE			b. Birth State/Birth Place		d. Age	e. Sex	f. Marital Status: <input type="checkbox"/> Mar. <input type="checkbox"/> Sep. <input type="checkbox"/> Sing. <input type="checkbox"/> Wid. <input type="checkbox"/> Div.		
a. Last Name	First Name	M.I.							
			c. Relationship						
g. Date of Birth Mo./Day/Yr.	h. Height and Weight	i. Social Security Tax ID No.		j. Has additional insured used tobacco in any form during the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
k. Residence Address No. & Street _____					l. Occupation Job title/duties (Be specific)				
City, State _____ ZIP _____					m. Employed by and kind of business		n. Date of employment Month _____ Year _____		
3. OWNER (If other than Proposed Insured)			b. Age		c. Relationship		d. Social Security Tax ID No.		
a. Last Name	First Name	M.I.							
e. Residence Address No. & Street _____					f. CONTINGENT OWNER (If any) Name, relationship				
City, State _____ ZIP _____									
4. BENEFICIARY—First			Relationship	Age	BENEFICIARY—Second			Relationship	Age
a. Name					b. Name				
5. CHILDREN PROPOSED FOR INSURANCE:			M.I.		b. Date of birth Mo./Day/Yr.	c. Age	d. Sex	e. Relationship to Prop. Ins.	f. Height & Weight
a. Last Name	First Name								
g. Has the name of any child under age 18 been omitted? <input type="checkbox"/> Yes (Explain) <input type="checkbox"/> No					h. Is any child not living at the same address with the Proposed Insured? <input type="checkbox"/> Yes (Explain) <input type="checkbox"/> No				

**PAGE 2 IN CONTINUATION OF AND BECOMING A PART OF AN APPLICATION TO AMERICAN NATIONAL INSURANCE COMPANY, GALVESTON, TEXAS**

**6. COMPLETE FOR UNIVERSAL LIFE PLANS**

a. Plan of Insurance b. Specified Amount

\$

c. Death Benefits Options-Elect One  Option A  Option B

d. Optional Benefits

1.  Waiver of Minimum Premium ..... \$ \_\_\_\_\_

2.  Accidental Death Benefit ..... \$ \_\_\_\_\_

3.  Children's Term Rider ..... \$ \_\_\_\_\_

4.  Spouse's Term Rider ..... \$ \_\_\_\_\_

5.  Guaranteed Increase Option ..... \$ \_\_\_\_\_

6.  Other ..... \$ \_\_\_\_\_

e. Planned Periodic Premium ..... \$ \_\_\_\_\_

f. Single Premium or Lump Sum Deposit ..... \$ \_\_\_\_\_

**7. FOR VARIABLE LIFE ONLY**

a. Select One or More Funds and Indicate Allocation

Money Market \_\_\_\_\_ %  Managed \_\_\_\_\_ %

Growth \_\_\_\_\_ %  \_\_\_\_\_ %

Balanced \_\_\_\_\_ % Total (must equal 100%)

b. SUITABILITY FOR VARIABLE LIFE ONLY Yes No

**Do you understand that the death benefit and cash value may increase or decrease depending on the investment return of the contract?**

**Do you believe that this contract will meet your insurance needs and financial objectives?**

**Did you receive the appropriate Fund Prospectus?**

**8. COMPLETE FOR TRADITIONAL PLANS**

a. Plan of Insurance b. Face Amount

\$

c. Additional Benefits by Rider:

Acc. Death \$ \_\_\_\_\_  Premium Refund

Dis. P.W. \_\_\_\_\_  CTR \_\_\_\_\_

Dis. P.W. both insureds \_\_\_\_\_  SLT \_\_\_\_\_

AIO \$ \_\_\_\_\_  Term Rider Plan \_\_\_\_\_

Premium Payer \_\_\_\_\_

(complete form 614) Amt. \$ \_\_\_\_\_

Other: (specify) \_\_\_\_\_  Annuity Rider \_\_\_\_\_

d. Premium:

Life \$ \_\_\_\_\_ Annuity \$ \_\_\_\_\_

e. If all proposed insureds are acceptable risks on a non-rated 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

f. Dividend Option for Participating Plan Only:

Cash (Option 1)  Accumulations (Option 4)

Premium Reduction (Option 2)  One-Year Term (Option 5)

Paid-Up Additions (Option 3)

g. Automatic Premium Loan elected  Yes  No

(In Rhode Island APL is required unless elected otherwise)

**9. PREMIUM DATA** Amount Paid with Application \$ \_\_\_\_\_

a. Mode b. Method

Ann.  Direct - name and address where premium notices to be sent if other than Insured's. \_\_\_\_\_

S.A. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Qtr.  PAC - (Submit form #2011 and Voided Check)

Mo.  Franchise - Name \_\_\_\_\_ Number \_\_\_\_\_

Sing. Prem.  Gov't Allotment - Payee Name

Allotment Type  A  B  C  D Rank \_\_\_\_\_ Branch \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Special Dating Instructions: Issue Age \_\_\_\_\_ Issue Date \_\_\_\_\_

**10.a. 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	Acc. Death	Dis. Inc.	See "b" below

b. Will the insurance or annuity applied for replace or use cash values of any existing insurance or annuity policy issued by any company? If "Yes," indicate which one(s) Yes No

**11.** Has any proposed insured ever applied for life, accident or health insurance or for reinstatement of any such insurance which was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate? If "Yes," give details. Yes No

**12.** Has any proposed insured in the last six (6) months, applied for or do they contemplate applying for other insurance with this or any other company? If "Yes," state how much, to whom and when. Yes No

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

**14.** Has any proposed insured ever engaged in, or do they intend to engage in, any hazardous avocation or sport, such as skin diving, parachuting, hang gliding, vehicle racing, or other hazardous avocations(s)? If "Yes," complete and submit appropriate questionnaire. Yes No

15. Family Physician, Specialist, or Clinic for:

a. Proposed Insured

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Tel. \_\_\_\_\_  
Reason \_\_\_\_\_

b. Additional Person Proposed for Insurance

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Tel. \_\_\_\_\_  
Reason \_\_\_\_\_

16. HAS ANY PROPOSED INSURED(S):

Yes No

- a. Any abnormality, deformity, disease or disorder or presently receiving treatment or taking medicine of any kind?
- b. Ever had a surgical operation or been advised to have an operation which was not performed?
- c. Ever had an x-ray, electrocardiogram, blood or urine test or other laboratory test? If "yes," state why, when, where, and by whom.
- d. Ever made claim for or received any insurance benefit, compensation or pension, government or otherwise, on account of an injury or sickness?
- e. Any impairment of sight or hearing?
- f. Ever been under observation or treatment in any hospital, sanitarium, clinic or rest home?
- g. Ever received counseling or treatment regarding the use of alcohol or drugs?

- h. Ever used barbiturates, amphetamines, hallucinatory drugs, heroin, opiates or other narcotics, except as prescribed by a physician?
- i. Ever had or been treated for high or low blood pressure, chest pain or for sugar in the urine; or for cancer in any form?
- j. Ever been told he or she had an Immune Deficiency Disorder, AIDS, the AIDS Related Complex (ARC) or test results indicating exposure to the AIDS virus?
- k. Consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application?
- l. Are all Proposed Insured(s) now in good health?
- m. If any Proposed Insured is less than one year old, give birth weight \_\_\_\_\_ lb. \_\_\_\_\_ oz.  
Was birth considered premature?

Yes No

17. Give full details below of all "Yes," answers to question 16 a-k & m and if answer is "No" on 16 - l.

Person	Qstn Num.	Reason, condition, disease, or injury, etc.	Date	Degree of recovery	Name and address of attending physician (Street, City, State)

**APPLICATION DECLARATIONS & AGREEMENTS**

Each of the undersigned declares for themselves, and all other interested parties, that all of the answers in the 3 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 any one concerning any proposed insured(s) if not in writing in this application or any supplement to it; 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; or (ii) any Policy issued on this application.

Dated at \_\_\_\_\_

City State

this \_\_\_\_\_ day of \_\_\_\_\_,

Witnessed by \_\_\_\_\_

Signature of Licensed Agent

Print Agent's Name \_\_\_\_\_

Signature of Proposed Insured (If age 16 or older)

Signature of Additional Person Proposed for Insurance

Signature of Owner or Premium Payer

State License Number \_\_\_\_\_

**SIGNATURE REQUIRED IF CONDITIONAL RECEIPT TO BE DETACHED**

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.

Signature of Proposed Insured (if age 16 or older)

Signature of Premium Payer

SOLICITING AGENT'S REPORT-THESE QUESTIONS MUST BE ANSWERED IN EVERY CASE

18. a. How long have you personally known the Proposed Insured? Years \_\_\_\_\_ Months \_\_\_\_\_
b. What is your estimate of the premium payer's annual income \$ \_\_\_\_\_ and worth? \$ \_\_\_\_\_
c. Did you see each person proposed for insurance when the application was completed? Yes No
d. By whom will premiums be paid? Owner Applicant Other
e. If the Proposed Insured is a child, how much insurance does the Premium Payer have in force on his/her own life?
f. Give any other surname(s) used by any proposed insured in last 5 years:
g. If beneficiary is not a relative explain insurable interest.

h. Has any industrial, intermediate, M.D.O., or Ordinary Insurance with this company on the life of the Proposed Insured been lapsed, surrendered for cash, or placed on reduced paid-up or extended insurance within the last twelve months, or is any such action now in process or planned? Yes No (If "Yes," list details below.)

Table with 9 columns: Policy Number, Issue Date, Plan, Prem., Amount, Ind., Intermed., M.D.O., or Ord., If Ind., Intermed., or M.D.O., give D.L.P., Lapsing Agent's Name, Field Office Code

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. You further certify that, to the best of your knowledge and belief, such person is of good moral character and temperate habits, and you know nothing that is not stated herein that would adversely affect such person's insurability. Yes No
j. As Agent, did you determine this applicant's insurable needs and/or financial objectives?
k. As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved?
l. As Agent, have you complied with State Replacement Regulations?
m. As Agent, did you include individualized sales proposals in your presentations? (If Proposed Insured replaces plans, the comparative information forms for each policy to be replaced, and copies of all sales material must be included with this application sent to Home Office.)

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_
Licensed Agent's Signature
Home Service District Code 2- \_\_\_\_\_ Agency No. \_\_\_\_\_ Agent P.C. No. \_\_\_\_\_
Corporation Name \_\_\_\_\_ Agent e-mail \_\_\_\_\_ Tax I.D. \_\_\_\_\_
Branch Ofc. No. (and PSO No.) \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

19. Special issue instructions to Home Office:
Additional Policy Plan & Amount \_\_\_\_\_ Alternate Policy Plan & Amount \_\_\_\_\_
Special Instructions: \_\_\_\_\_
Are Commissions to be split? Yes No
If yes and split 50/50, list both agent's names and PC #s: \_\_\_\_\_
Otherwise, complete and submit form #6151
Special Beneficiary Settlement Options: Yes No If "Yes," complete and submit a modification form. (1048)

20. Premium quoted includes anticipated flat dollar extra:
Yes No 1st insd. 2nd insd. If "Yes," \$ \_\_\_\_\_ extra per thousand.

21. INDICATE WHICH OF THE FOLLOWING REQUIREMENTS WERE ORDERED: SEE CURRENT MARKETING BULLETIN FOR REQUIREMENTS
Oral Fluid Test Collected by Agent Date Ordered?
From which approved Paramed Company? Exam by Physician, Full Blood, HOS
Paramed, HOS EKG
Paramed, Full Blood, HOS X ray
Full Blood, Physical Measurements, HOS Other:
APS Dr/Clinic:
Was APS paid in advance? Yes No If "Yes" enter check no. Amount \$
Is inspection required? Yes No If "Yes," ordered? Yes No If "Yes," Company:

22. Has the application been reviewed for omissions and errors? Yes No
If "Yes," by (name) \_\_\_\_\_

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me, my spouse, and my children, or our health to give to the American National Insurance Company or its Reinsurers any such information about me, my spouse and my children with reference to us, our health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I have received notification describing the Medical Information Bureau, and this authorization will be valid for two (2) years from its date.

To facilitate rapid submission of such information, I authorize all the above sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the American National Insurance Company to collect and transmit such information. A photo copy of this authorization shall be as valid as the original.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

\_\_\_\_\_

Witness

\_\_\_\_\_

Signature of Additional Person Proposed for Insurance

**THIS RECEIPT SHALL BE VOID  
IF ALTERED OR MODIFIED**

**CONDITIONAL RECEIPT  
AMERICAN NATIONAL INSURANCE COMPANY  
One Moody Plaza, Galveston, Texas 77550-7999**

**PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY  
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK**

I have received \$ \_\_\_\_\_ in connection with an application for life insurance bearing the same 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 insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application, and in good health; and
- (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.

Dated at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
City, State Month, Day Year Signature of Licensed Agent

I have read this conditional receipt. It has been explained to me by the agent and I understand and agree to all conditions and limitations.

\_\_\_\_\_  
Signature of Proposed Insured (if age 16 or older)

\_\_\_\_\_  
Signature of Owner or Premium Payer

**AGENT: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE PROPOSED INSURED**  
**AMERICAN NATIONAL INSURANCE COMPANY**  
**ONE MOODY PLAZA**  
**GALVESTON, TEXAS 77550-7999**

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 their 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.

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901(TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112.

The American National Insurance Company, or its reinsurers, may also release information in 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.

**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.



**AMERICAN NATIONAL INSURANCE COMPANY**

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Tracey Johnfroe, Life Policy Analyst  
Product Development – Actuarial  
One Moody Plaza, 14<sup>th</sup> Floor  
Galveston, Texas 77550

e-mail: [tracey.johnfroe@ANICO.com](mailto:tracey.johnfroe@ANICO.com)  
Phone: (409) 763-4661 x 5438  
Fax: (409) 766-6933

### **EXPLANATION OF VARIABLE FIELDS WITHIN FORM 4165**

The Application: Financial Statement Supplement form submitted contains the variable fields as described below:

Mailing Address: This field will only be updated in the event the mailing address where applications are sent is changed.

Business Phone and Fax Number: This field will only be updated in the event the business and fax phone numbers are changed.



**AMERICAN NATIONAL INSURANCE COMPANY**

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Tracey Johnfroe, Life Policy Analyst II  
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Phone: (409) 763-4661 x 5438  
Toll Free (800) 899-6809 x 5438  
Fax: (409) 766-6933

December 3, 2008

Arkansas Insurance Department  
Compliance - Life and Health  
1200 West Third Street  
Little Rock AR 72201-1904

<b>American National Insurance Company</b>	<b>Filing of Form 4165</b>
<b>NAIC Number 60739</b>	<b>FEIN 74-0484030</b>
<b>SERFF Tracking Number</b>	<b>AMNA-125909789</b>

Sir or Madam

Please find the above referenced form attached for your department's review and approval. This is a new form and is not intended to replace any previously approved forms.

Form 4165 is a supplemental application used to gather financial information about the applicant and will be used with all life products which have a face amount ranging from two-million dollar to ten million dollars to assess the financial need in relation to amount applied for. This form is used at an underwriter's discretion if supporting documentation for financial information on such cases is not provided or incomplete, and could possibly be used on smaller face amounts, but not likely for any amount less than one million dollars.

When used, this form will be attached to and made a part of the application for life insurance, and would subsequently be made a part of the policy contract. This form will be used with previously approved life application Form 9261, approved by your department on January 6, 2002.

Additional components / information associated with this filing are as follows and have been enclosed (when applicable) for your review:

- Form 4165 was filed in Texas, our state of domicile on November 20, 2008 and is pending review and approval.
- Payment for the required filing fee has been transmitted via EFT through SERFF in the amount of \$50.00.
- Statement of Variability
- Certificate of Readability

Should any additional information be required, or if there are any questions, please contact me at the phone number or e-mail address provided above.

Sincerely,

**Tracey Johnfroe**

Tracey Johnfroe, Life Policy Analyst II