

SERFF Tracking Number: AMNA-126066501 State: Arkansas  
Filing Company: American National Insurance Company State Tracking Number: 42565  
Company Tracking Number: 582  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Reinstatement Application  
Project Name/Number: /

## Filing at a Glance

Company: American National Insurance Company

Product Name: Reinstatement Application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMNA-126066501 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 42565

Co Tr Num: 582

Author: Tracey Johnfroe

Date Submitted: 06/03/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 06/04/2009

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/04/2009

Deemer Date:

Submitted By: Tracey Johnfroe

Filing Description:

Arkansas Insurance Department

Compliance - Life and Health

1200 West Third Street

Little Rock AR 72201-1904

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/04/2009

Created By: Tracey Johnfroe

Corresponding Filing Tracking Number:

American National Insurance Company

Filing of Form 582 - Application for Reinstatement

NAIC: 60739 FEIN: 74-0484030

SERFF Tracking Number AMNA-126066501

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Greetings 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 582-AR is an application for reinstatement of life insurance policies and, in accordance with the policy provision regarding reinstatement, must be completed and submitted to Us as a part of the formal request for reinstatement of their policy. Along with the application for reinstatement, a Declaration of Insurability is required to be submitted. This form was filed with your department on February 27, 2009 as Form 3517-AR and approved by your department on March 3, 2009.

This reinstatement application can be used with all life product types offered by American National Insurance Company.

This application will not be attached to or made a part of the policy contract. The completed form is retained at our Home Office.

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

- Payment for the required filing fee has been transmitted via EFT through SERFF in the amount of \$100
- Statement of Variability
- Certificate of Readability

Should any additional information be required, or if there are any questions, please contact me at phone number (409) 763-4661 X 5438 or e-mail address [tracey.johnfroe@anico.com](mailto:tracey.johnfroe@anico.com).

## Company and Contact

### Filing Contact Information

Tracey Johnfroe, Life Policy Analyst  
One Moody Plaza  
Actuarial Product Development  
14th Floor  
Galveston, TX 77550

[Tracey.Johnfroe@ANICO.com](mailto:Tracey.Johnfroe@ANICO.com)  
409-463-4661 [Phone] 5438 [Ext]  
709-766-6933 [FAX]

### Filing Company Information

American National Insurance Company CoCode: 60739 State of Domicile: Texas

SERFF Tracking Number: AMNA-126066501 State: Arkansas  
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 Product Name: Reinstatement Application  
 Project Name/Number: /  
 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: \$100.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	\$100.00	06/03/2009	28310929

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/04/2009	06/04/2009

*SERFF Tracking Number:* AMNA-126066501      *State:* Arkansas  
*Filing Company:* American National Insurance Company      *State Tracking Number:* 42565  
*Company Tracking Number:* 582  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Reinstatement Application  
*Project Name/Number:* /

## **Disposition**

Disposition Date: 06/04/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Reinstatement		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	Form 582-AR	Application/ Enrollment Form Application for Reinstatement	Initial			Form 582-AR.pdf



Application for Reinstatement

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

Policy No. \_\_\_\_\_



THIS AREA TO BE COMPLETED BY AGENT IF POLICY IS DEBITIZED ORDINARY OR M.D.O.

Revoke to: District \_\_\_\_\_ | Agency: \_\_\_\_\_ | Month Code of Collection: \_\_\_\_\_ | Lapsing D.L.P. Code: \_\_\_\_\_
Amount of Collection: \$ \_\_\_\_\_ | Premium: \$ \_\_\_\_\_ | Amount of Insurance: \_\_\_\_\_ | Date of Issue: \_\_\_\_\_

1. PRIMARY PROPOSED INSURED

a. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ Occupation/Job Title \_\_\_\_\_
b. Date of birth: Month/Day/Year \_\_\_\_\_ c. Age last birthday \_\_\_\_\_ d. Height \_\_\_\_\_ e. Weight \_\_\_\_\_ Annual Income \_\_\_\_\_ Net Worth \_\_\_\_\_
f. Residence address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ g. Personal Telephone \_\_\_\_\_

2. ADDITIONAL PROPOSED INSURED

a. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ Occupation/Job Title \_\_\_\_\_
b. Date of birth: Month/Day/Year \_\_\_\_\_ c. Age last birthday \_\_\_\_\_ d. Height \_\_\_\_\_ e. Weight \_\_\_\_\_ Annual Income \_\_\_\_\_ Net Worth \_\_\_\_\_
f. Residence address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ g. Personal Telephone \_\_\_\_\_

3. SECONDARY OR ALTERNATE ADDRESSEE (if applicable)

Name \_\_\_\_\_ Address: Number/Street \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

4. MEDICAL HISTORY QUESTIONS—LIFETIME

(For questions "4.a." through "6.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 7.)

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

HAS ANY PROPOSED INSURED EVER ...

b. had a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels? .....  Yes  No
c. had cancer, a tumor or abnormal growth of any kind? .....  Yes  No
d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? .....  Yes  No

5. MEDICAL HISTORY QUESTIONS—LAST TEN YEARS

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

a. had seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system?  Yes  No
b. had asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system? .....  Yes  No
c. had any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis? .....  Yes  No
d. had any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? .....  Yes  No
e. had diabetes or any disease of the thyroid or other gland? .....  Yes  No
f. had arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin? .....  Yes  No
g. had treatment or counseling for use of alcohol or alcoholism? .....  Yes  No
h. had treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? .....  Yes  No
i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed? .....  Yes  No
j. If any proposed insured(s) is less than one year old, give birth weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz. Was birth premature? .....  Yes  No

6. 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

7. MEDICAL HISTORY EXPLANATIONS (Give full details below of all "Yes" answers to questions "4.a." through "6.c.")

Question Person \_\_\_\_\_ Reason, condition, disease, injury, etc. \_\_\_\_\_ Date \_\_\_\_\_
% of recovery \_\_\_\_\_ Name of attending physician \_\_\_\_\_ Attending physician address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_



**(Continuation of Section 7)**

Question	Person	Reason, condition, disease, injury, etc.	Date
% of recovery	Name of attending physician	Attending physician address: Number/Street	City State

Add a separate sheet of paper signed, dated, and witnessed for additional medical history explanations.

**8. NON-MEDICAL HISTORY**

a. 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.) | \_\_\_\_\_

**DECLARATION OF INSURABILITY**

The undersigned hereby makes application for reinstatement of this policy which lapsed for non-payment of premium or other amounts due. The preceding questions refer to the person named in the policy as Insured, and if premium payer benefits are involved, to the Premium Payer, and if a Family Policy, to all persons insured or to be insured there under. (Check policy to determine persons covered by it.)

**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.

**REINSTATEMENT DECLARATIONS AND AGREEMENTS**

Each of the undersigned declares for themselves, and all other interested parties, that all of the answers in all pages of this application for reinstatement and any supplements to it are full, complete and true. Each of the undersigned agrees that: (1) the statements and answers above refer to the person named in the policy as the Insured, and if Premium Payer benefits are involved, to the Premium Payer, and, if a family policy is involved, to all persons insured or to be insured thereunder; (2) this application and all statements and answers contained herein shall be considered a supplement to the original application, shall form the basis for reinstatement and shall become a part of the contract of insurance for which application for reinstatement is made; (3) all statements and answers made in the original application for this policy are hereby ratified and confirmed except such as are modified by statements or answers herein contained; (4) the reinstatement of this policy shall not be effective until (a) approved at the Company's Home Office and (b) all premiums in default and additional payments required for reinstatement of this policy are received at the Company's Home Office during the lifetime and good health of all persons insured or to be insured under this policy; (5) if the policy is not reinstated by the Company, its only liability in connection with this application for reinstatement shall be for the refund of all sums tendered herewith; (6) if the Company shall approve such reinstatement, this policy shall be incontestable after it has been in force during the lifetime of the Insured(s) for two years from the date of approval of this application (except for nonpayment of premiums and except for disability benefits or accidental death benefits). The incontestability provision of this policy is modified accordingly; (7) information disclosed to or knowledge on the part of any medical examiner or representative of the Company as to any facts pertaining to any person insured or to be insured under this policy shall not be considered as knowledge of the Company unless reduced to writing and made a part of this application.

**FRAUD STATEMENT**

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.

**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).

I have on \_\_\_\_\_ made payment of \$ \_\_\_\_\_ to \_\_\_\_\_ as a consideration for reinstatement for which I  DO  DO NOT hold provisional receipt.

Date: Month/Day/Year \_\_\_\_\_ Signed at: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Witnessed by: Signature of witness or licensed agent \_\_\_\_\_ Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

X \_\_\_\_\_ X \_\_\_\_\_

Print agent's name \_\_\_\_\_ Signature of additional person(s) proposed for insurance

\_\_\_\_\_ X \_\_\_\_\_

Agent's state license number / company personal code \_\_\_\_\_ Signature of owner if other than proposed insured

\_\_\_\_\_ X \_\_\_\_\_



Policy No. \_\_\_\_\_

**CONDITIONAL RECEIPT**

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

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

**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 reinstatement bearing the same policy 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, or reinstatement 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 after the date of lapse. 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 \_\_\_\_\_

**AGENT: THIS NOTICE MUST BE 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 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.

**Medical Information Bureau (MIB) Pre-notification** — Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the bureau's file, you may contact the bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the bureau's information office is: Medical Information Bureau, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, website address [www.mib.com](http://www.mib.com), telephone number (617) 426-3660. The American National Insurance Company or its reinsurer(s) may also release information in its file to other life 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.

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Product Name: Reinstatement Application  
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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR - Readability Certification.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Not applicable - this is not a policy filing <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> AR - Statement of Variability.pdf		



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## READABILITY CERTIFICATION

We hereby certify that the following form(s) meet the requirements of the Readability Insurance Policies Act and score at least a minimum of 50 on the Flesch rating scale:

<u>Form</u>	<u>Form Name</u>
582-AR	Application for Reinstatement

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



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 582-AR

The Application for reinstatement 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.