Filing at a Glance

Company: American National Insurance Company

Product Name: AD - REPL
SERFF Tr Num: AMNA-126510335
State: Arkansas

TOI: L08 Life - Other
SERFF Status: Closed-Approved-Closed
State Tr Num: 45395

Sub-TOI: L08.000 Life - Other
Co Tr Num: AD - REPL
State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Linda Bird

Author: Tyra Reed
Disposition Date: 04/12/2010

Date Submitted: 04/09/2010
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:

State Filing Description:

General Information

Project Name:
Status of Filing in Domicile: Pending

Project Number:
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Individual

Submission Type: New Submission
Group Market Size:

Overall Rate Impact:
Group Market Type:

Filing Status Changed: 04/12/2010
Explanation for Other Group Market Type:

State Status Changed: 04/12/2010

Deemer Date:
Created By: Tyra Reed

Submitted By: Tyra Reed
Corresponding Filing Tracking Number:

Filing Description:

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
Form REPL-D1(10)– Appendix B – Notice Regarding Replacement
Form REPL-D2(10) – Appendix C – Important Notice: Replacement of Life Insurance or Annuities for Direct Response Insurers
SERFF Tracking Number: AMNA- 126510335 Company Tracking Number: AD-REPL

Dear Reviewer:

Please find attached the above listed form(s) for your department's review and approval. These forms are new, and will

not replace any previously approved forms.

Form REPL-D1 is the Notice Regarding Replacement form that will be used in conjunction with our direct response products.

Application forms 10291-AR and 10292-AR contain replacement questions that are to be completed at the time of application. Form REPL-D1(10) is provided with the policy at the time of policy delivery If the application form is returned to us and indicates that no replacement is involved, or fails to answer the question (leaves blank). Form REPL-D2(10) is provided with the policy at the time of policy delivery when the application form indicates that replacement is involved. A self-address stamped envelope is also provided in order for the completed Form REPL-D2(10) to be returned to us.

Filing/Approval information for forms 10291-AR and 10292-AR:

Form 10291-AR was approved by your department on 02/03/10 under tracking number(s) AMNA-126473289 / 44732.

Form 10292-AR was approved by your department on 3/2/2010 under tracking numbers(s) AMNA-126513629 / 45043.

Additional information/document is as follows:
• Statement of Variability
• The required filing fee of $100 has been submitted with this filing via EFT.

Company and Contact

Filing Contact Information

Tyra Reed, Policy Analyst
One Moody Plaza
Product Development--14th Floor
Galveston, TX 77550

tyra.reed@anico.com
409-763-1112 [Phone] 5222 [Ext]
409-766-6933 [FAX]

Filing Company Information

American National Insurance Company
One Moody Plaza
Galveston, TX 77550
(409) 763-4661 ext. [Phone]

CoCode: 60739
Group Code: 408
Group Name:
FEIN Number: 74-0484030

State of Domicile: Texas
Company Type:
State ID Number:

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	04/09/2010	35532103

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/12/2010	04/12/2010

Disposition

Disposition Date: 04/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMNA-126510335*	*State:*	*Arkansas*
Filing Company:	*American National Insurance Company*	*State Tracking Number:*	*45395*
Company Tracking Number:	*AD - REPL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*AD - REPL*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Cover Letter		Yes
Form	Appendix B – Notice Regarding Replacement		Yes
Form	Appendix C – Important Notice: Replacement of Life Insurance or Annuities for Direct Response Insurers		Yes

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form REPL-D1(10)	Other	Appendix B – Notice Regarding Replacement	Initial			Form REPL-D1(10).PDF
	Form REPL-D2(10)	Other	Appendix C – Important Notice: Replacement of Life Insurance or Annuities for Direct Response Insurers	Initial			Form REPL-D2(10).PDF

APPENDIX B

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

Processing Center: 4500 Lockhill-Selma Rd, San Antonio, Texas 78249

APPENDIX C

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
FOR DIRECT RESPONSE INSURERS

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 and ask that you answer the following questions and consider the questions on the remainder of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

   ____ YES ____ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ____ YES ____ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract 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.

AMERICAN NATIONAL

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:

PREMIUMS: Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: 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 expenses 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 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?

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

Will you pay surrender charges on your old contract?
Do you know the interest rates guarantees for the new contract?
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?

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Flesch Certification

Bypass Reason: Form used as those provided by the Department.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Form 10291-AR was approved by your department on 02/03/10 under tracking number(s) AMNA-126473289 / 44732.

Form 10292-AR was approved by your department on 3/2/2010 under tracking numbers(s) AMNA-126513629 / 45043.

Attachments:

10291-AR.pdf

10292-AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

AR - MEMORANDUM OF VARIABLE MATERIAL.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter

Comments:

Attachment:

AR.pdf

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

American National Insurance Company
P.O. BOX 696740
San Antonio, TX 78269

ABOUT YOU

Name: _____ E-mail: _____

Address: _____ Apt. _____

City: _____ State: _____ ZIP Code: _____

Social Security Number: _____ – ___ – _____ ☐ Female ☐ Male Height: __ ft. ___ in. Weight: _____

Home Phone:(_____) _____ – _____ Work Phone:(_____) _____ – _____ Household Income: _____

Date of Birth: ____ / ____ / _____ Place of Birth: _____ Source of Income: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Are you a U.S. Citizen? ☐ Yes ☐ No If 'No', do you have a permanent resident status? ☐ Yes ☐ No

Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No Occupation: _____

YOUR HEALTH

1. Have you been diagnosed by a member of the medical profession as having an immune deficiency disorder, AIDS, AIDS Related Complex (ARC), or received test results indicating exposure to the AIDS virus? ☐ Yes ☐ No

2. Within the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: heart or circulatory system disease; blood or immune system disease (excluding a positive HIV test); cancer (excluding basal and squamous cell skin cancer); kidney, liver, pancreas, or lung disease (excluding asthma and bronchitis); alcoholism or alcohol or drug abuse; stroke; TIA; Alzheimer's or hospitalized for any mental or nervous system disorder; or have you attempted suicide? ☐ Yes ☐ No

3. Within the past 5 years have you: been in prison or convicted of a felony; had a driver's license suspended or revoked; been convicted of driving while intoxicated (DWI) or driving under the influence (DUI); received treatment by a home health care provider; or admitted to or confined in a hospital, nursing home, extended care or special treatment facility for any condition other than child birth? ☐ Yes ☐ No

4. Within the past 3 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: high blood pressure; diabetes; asthma; or chronic bronchitis? If "yes" provide details (dates of treatment, test results, diagnoses, medications, etc.): _____ ☐ Yes ☐ No

5. Within the past 2 years have you been: disabled or missed 10 or more consecutive days of work due to illness; advised to have any test or treatment that has not been performed; advised to take any medication that you are not now taking; or needed help with dressing, eating, walking or breathing (including the use of oxygen)? If "yes" provide details (dates of treatment, test results, diagnoses, medications, etc.): _____ ☐ Yes ☐ No

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Term to age 80 (7) Amount: ☐ $250,000 ☐ $150,000 ☐ $100,000 ☐ Other: $ _____

Beneficiary: _____ Relationship: _____

If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.

If Beneficiary is not a relative, please explain insurable interest: _____

Automatic Premium Loan Provision Requested? ☐ Yes ☐ No

Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No

If Yes, name of company and policy number(s): _____ Amount: _____

PAYMENT SELECTION

I authorize the collection of premiums in accordance with the payment method selected, unless instructed otherwise.

1. ☐ Automatic monthly deductions from my checking or savings account. (Enclose a numbered deposit slip or voided check.)
2. ☐ Charge monthly premiums to my: ☐ Visa ☐ MasterCard ☐ Discover ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐
   Visa, MasterCard or Discover Account Number Exp. Date
3. ☐ Bill me. (Send no money now.)

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION AND AGREEMENTS

I authorize any physician, medical provider, hospital, clinic, medical facility, insurance company, insurance support organization, pharmacy, pharmacy benefit manager, laboratory, paramedical facility and MIB, Inc., to provide to American National Insurance Company (ANICO) or to any agent, attorney, consumer reporting agency or administrator, including medical record retrieval service, acting on ANICO'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 drugs, alcohol or tobacco usage of the applicants(s). It is understood that: ANICO or its reinsurers, attorneys or medical director may disclose such information to the aforementioned parties for underwriting, record clarification or explanation, and/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: a) such information will be used by ANICO for underwriting and insurability decisions; b) I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; c) a copy of this authorization is as valid as the original; d) any authorized representative of the proposed insured may obtain a copy of this authorization on request; e) this authorization is valid for 24 months from the date signed; f) I may inspect or copy any information used or disclosed under this authorization; g) and I may revoke the authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: ANICO at the above address. I have received the Exchange of Information Notice.

I declare that the answers and statements to the questions above are complete and true to the best of my knowledge and belief. I understand and agree: that the answers and statements will be relied upon by ANICO in determing whether to issue coverage and the amount of the premium; and that ANICO will have no liability until a policy is issued, delivered to and accepted by me; and the first premium due is paid in full while I am alive and in the same health condition as described above. I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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 Applicant : X _____ **Date X** _____/_____/_____

10291-AR

APPLICATION FOR JUVENILE LIFE INSURANCE

Life Insurance Services-Direct Market
P.O. BOX 696700
San Antonio, TX 78269

ABOUT YOU

Parent's Name: _____ Parent's Policy Number (if known): _____

Billing Address: _____ Apt._____ Home Phone._____

City:_____ State:_____ ZIP Code:_____

Persons Proposed for Insurance:

Name of Person*	Social Security No.	Birth Date	Birthplace	Relationship	Height	Weight	Life Ins in Force

* Attach a separate sheet if needed.

AMOUNT OF COVERAGE

Please indicate the number of units of coverage desired:_____ Units (1 Unit = $2000 per child; maximum of 8 units)

Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No

If "Yes", Name of company and policy number: _____ Amount: _____

Amount of life insurance in force on proposed insureds': Father:_____Mother: _____

HEALTH

1. Has any person proposed for insurance:

a. In the past 5 years, consulted a physician for, been diagnosed with, or had treatment for: cancer, diabetes, heart disease, paralysis, seizures, mental disorder or retardation; asthma or other disease of the respiratory system; blood (excluding a positive HIV {Human Immunodeficiency Virus} test), liver, or kidney disease; or alcohol or drug abuse? ☐ Yes ☐ No

b. In the past 3 years, been admitted or confined to a hospital, or special treatment facility (other than at birth unless confined for more than 5 days), or had a driver's license suspended or revoked? ☐ Yes ☐ No

c. Been diagnosed by a member of the medical profession as having an immune deficiency disorder, AIDS, AIDS Related Complex (ARC), or received test results indicating exposure to the AIDS virus? ☐ Yes ☐ No

2. Does any person proposed for insurance have a congenital disorder, birth defect, injury or health condition that requires ongoing medical care, or has any such person attempted suicide? ☐ Yes ☐ No

3. Is any person proposed for insurance currently taking any medication(s)? ☐ Yes ☐ No

4. Please explain all "Yes" answers to questions 1, 2 and 3 in the space below. Attach a separate sheet if necessary.

Question No.	Name of Person	Nature of Disorder or Injury	Dates

AGREEMENTS - PLEASE READ AND SIGN

I have read the above questions and declare that the answers and statements are complete and true to the best of my knowledge and belief. I understand and agree that the answers and statements provided are the basis for any policy and rider issued by American National Insurance Company (ANICO), and no information about them will be considered to have been given to ANICO unless it is stated in the application. I understand that ANICO will have no liability until a policy and rider is issued on this application and delivered to and accepted by me; and the first premium due is paid in full while that Person(s) is alive and in the same health condition as described above.

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Signature of Parent : X _____ **Date X** _____/_____/_____

Signature of Children Age 18 or Older:

X _____ **Date X** _____/_____/_____

X _____ **Date X** _____/_____/_____

X _____ **Date X** _____/_____/_____

MEMORANDUM OF VARIABLE MATERIAL for Form REPL-D1(10) and Form REPL-D2(10)

This memorandum was prepared for use with Form REPL-D1(10) and Form REPL-D2(10), replacement forms for American National Insurance Company's direct marketing branch. Variable material contained in the replacement form is denoted by the use of brackets and the variable fields are as follows:

.

ADDRESS: (Street and/or PO Box, City, State and Zip Code). This filed will display the physical address and/or the post office box to where the completed form may be mailed. This address will coincide with the appropriate receiving department.

We certify that any change or modification to a variable item will be administered in accordance with your department's requirements regarding variable material, including any requirements for prior approval of a change or modification.

Tyra G. Reed, Life Policy Analyst III
Product Development – Actuarial
Home Office : One Moody Plaza, 14th Floor
Galveston, Texas 77550

e-mail: tyra.reed@ANICO.com
Phone: (409) 763-4661 x 5222
Fax: (409) 766-6933

April 9, 2010

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

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:

Form REPL-D1(10)– Appendix B – Notice Regarding Replacement

Form REPL-D2(10) – Appendix C – Important Notice: Replacement of Life Insurance or Annuities for Direct Response Insurers

SERFF Tracking Number: AMNA- 126510335 **Company Tracking Number: AD-REPL**

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Additional information/document is as follows:

- Statement of Variability
- The required filing fee of $100 has been submitted with this filing via EFT.

Sincerely,

Tyra G. Reed

Tyra G. Reed
Life Policy Analyst III