

SERFF Tracking Number: AMNA-126473289 State: Arkansas
Filing Company: American National Insurance Company State Tracking Number: 44732
Company Tracking Number: AD - SI APP
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: AD - SI APP
Project Name/Number: /

Filing at a Glance

Company: American National Insurance Company

Product Name: AD - SI APP

SERFF Tr Num: AMNA-126473289 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 44732

Sub-TOI: L08.000 Life - Other

Co Tr Num: AD - SI APP

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Tyra Reed

Disposition Date: 05/05/2010

Date Submitted: 02/01/2010

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: 05/05/2010

Explanation for Other Group Market Type:

State Status Changed: 02/03/2010

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:

10291-AR ;V Application for Individual Life Insurance

SERFF Tracking Number: AMNA- 126473289

Company Tracking Number: AD-SI APP

Dear Reviewer:

Please find attached the above listed form for your department's review and approval. This form is new, and will not replace any previously approved forms.

SERFF Tracking Number:	AMNA-126473289	State:	Arkansas
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10291-AR is a simplified issue life application. The recognized market where the application will be used is: direct mail and bank market. The application will be used to apply for previously approved individual simplified issue term life and whole life products. Currently, the application will be used to apply for the following policy forms:

- Form LCT09DM(10)
- Form LNCT09DM(10)
- Form RCT09DM(10)

These forms are individual term life policies and were approved by your department under SERFF Tracking Number AMNA-126425223 on 1/11/2010.

Within the application's Authorization to Obtain, Release and Disclose Medical Information and Agreements section, the applicant is asked to acknowledge their receipt of the Exchange of Information Notice. This notice is provided as a part of the solicitation materials and has been included in this submission as an informational document under the Supporting Documentation tab.

Additional information/supporting documentation included in this submission is as follows:

- „X Statement of Variability
- „X Certification of Compliance
- „X Payment of the required filing fee in the amount of \$ 50.00 has been submitted via EFT
- „X Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Company and Contact

Filing Contact Information

Tyra Reed, Policy Analyst	tyra.reed@anico.com
One Moody Plaza	409-763-1112 [Phone] 5222 [Ext]
Product Development--14th Floor	409-766-6933 [FAX]
Galveston, TX 77550	

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	

Filing Fees

SERFF Tracking Number: AMNA-126473289 State: Arkansas
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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	02/01/2010	33903864

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/05/2010	05/05/2010
Approved-Closed	Linda Bird	02/03/2010	02/03/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Electronic Screens	Judy Regini	05/05/2010	05/05/2010
Supporting Document	Telephone Screens and Disclosure Language	Judy Regini	05/05/2010	05/05/2010
Supporting Document	Process Summary	Judy Regini	05/05/2010	05/05/2010
Supporting Document	Screen Shot of Completed Application	Judy Regini	05/05/2010	05/05/2010
Supporting Document	Explanation Letter - Telephone and Online Amendment	Judy Regini	05/05/2010	05/05/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Re-Open	Note To Filer	Linda Bird	04/29/2010	04/29/2010
Request to Re-Open	Note To Reviewer	Judy Regini	04/29/2010	04/29/2010

SERFF Tracking Number: AMNA-126473289 State: Arkansas
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Product Name: AD - SI APP
Project Name/Number: /

Disposition

Disposition Date: 05/05/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMNA-126473289 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Exchange of Information Notice		No
Supporting Document	Statement of Variability		No
Supporting Document	Electronic Screens		No
Supporting Document	Telephone Screens and Disclosure Language		No
Supporting Document	Process Summary		No
Supporting Document	Screen Shot of Completed Application		No
Supporting Document	Explanation Letter - Telephone and Online Amendment		No
Form	Application for Individual Life Insurance		No

SERFF Tracking Number: AMNA-126473289 State: Arkansas
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Product Name: AD - SI APP
Project Name/Number: /

Disposition

Disposition Date: 02/03/2010

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	No	No
Supporting Document	Application	No	No
Supporting Document	Exchange of Information Notice	No	No
Supporting Document	Statement of Variability	No	No
Supporting Document	Electronic Screens	No	No
Supporting Document	Telephone Screens and Disclosure Language	No	No
Supporting Document	Process Summary	No	No
Supporting Document	Screen Shot of Completed Application	No	No
Supporting Document	Explanation Letter - Telephone and Online Amendment	No	No
Form	Application for Individual Life Insurance	No	No

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Project Name/Number: /

Amendment Letter

Submitted Date: 05/05/2010

Comments:

Thank you for re-opening this filing. I have attached to Supporting Documentation those documents related to the electronic and telephone processing.

J. Regini

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Electronic Screens

Comment:

AR_Online_(Part_1_PP_1-17).pdf

AR_Online_(Part_2_PP_18-33).pdf

User Added -Name: Telephone Screens and Disclosure Language

Comment:

AR_Telephone_(Part_1_PP_1-15).pdf

AR_Telephone_(Part_2_PP_16-28).pdf

Disclosure Scripts.pdf

User Added -Name: Process Summary

Comment:

Process_Summary.pdf

User Added -Name: Screen Shot of Completed Application

Comment:

10291-AR_ScreenShot.pdf

User Added -Name: Explanation Letter - Telephone and Online Amendment

Comment:

CoverLetter.pdf

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Project Name/Number: /

Note To Filer

Created By:

Linda Bird on 04/29/2010 08:49 AM

Last Edited By:

Linda Bird

Submitted On:

04/29/2010 08:50 AM

Subject:

Request to Re-Open

Comments:

Filing has been re-opened in order for amendment to be added to original submission.

SERFF Tracking Number: AMNA-126473289 State: Arkansas
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Product Name: AD - SI APP
Project Name/Number: /

Note To Reviewer

Created By:

Judy Regini on 04/29/2010 07:38 AM

Last Edited By:

Judy Regini

Submitted On:

04/29/2010 07:38 AM

Subject:

Request to Re-Open

Comments:

We would like to re-open this filing in order to amend the submission. We will be adding our online and telephone procedures for review and approval. Please advise if this is possible and what special filing requirements might exist.

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	10291-AR	Application/ Enrollment Form Individual Life Insurance	Initial			10291-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?
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...
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?
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.):
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.):

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
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 determining 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 / /

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Supporting Document Schedules

Item Status: **Status Date:**
Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR - CERTIFICATION OF COMPLIANCE.pdf

Item Status: **Status Date:**
Bypassed - Item: Application
Bypass Reason: application is form submitted for approval
Comments:

Item Status: **Status Date:**
Satisfied - Item: Exchange of Information Notice
Comments:
Attachment:
Exchange of Information Notice.pdf

Item Status: **Status Date:**
Satisfied - Item: Statement of Variability
Comments:
Attachment:
MEMORANDUM OF VARIABLE MATERIAL.pdf

Item Status: **Status Date:**
Satisfied - Item: Electronic Screens
Comments:
Attachments:

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 Product Name: AD - SI APP
 Project Name/Number: /
 AR_Online_(Part_1_PP_1-17).pdf
 AR_Online_(Part_2_PP_18-33).pdf

Item Status: **Status Date:**

Satisfied - Item: Telephone Screens and Disclosure Language

Comments:

Attachments:

AR_Telephone_(Part_1_PP_1-15).pdf
 AR_Telephone_(Part_2_PP_16-28).pdf
 Disclosure Scripts.pdf

Item Status: **Status Date:**

Satisfied - Item: Process Summary

Comments:

Attachment:

Process_Summary.pdf

Item Status: **Status Date:**

Satisfied - Item: Screen Shot of Completed Application

Comments:

Attachment:

10291-AR_ScreenShot.pdf

Item Status: **Status Date:**

Satisfied - Item: Explanation Letter - Telephone and Online Amendment

Comments:

Attachment:

CoverLetter.pdf



AMERICAN NATIONAL INSURANCE COMPANY

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):

Application form 10291-AR, when scored with each of the approved policy forms, achieves a score greater than the minimum of 40.

<u>Form</u>	<u>Form Name</u>	<u>Type of Form</u>
10291-AR	Application for Individual Life Insurance	Application

Rex D. Hemme

Vice President & Actuary

American National Insurance Company

tyra.reed@anico.com

Phone: (409) 763-4661 x5222 Fax: (409) 766-6933

Exchange of Information Notice

We are required to provide you the following disclosures to you:

Medical Information Bureau, Inc. (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. American National Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Important Note: Vermont: HIV information will be released to the MIB only using a non-specific test result code.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential.

You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA Patriot Act Notice

The USA Patriot Act requires that we establish an Anti-Money Laundering ("AML") Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.



MEMORANDUM OF VARIABLE MATERIAL for 10291

This memorandum was prepared for use with 10291, the Application for Individual Life Insurance. 10291 is an individual life insurance application used for simplified issue products marketed through American National Insurance Company's direct marketing branch. Variable material contained in the application is denoted by the use of brackets and the variable fields are as follows:

RECEIVING DEPARTMENT NAME: This field will display the name of the department to whose attention the completed form may be mailed. The name of the department is denoted as variable to allow for flexibility in our processing procedures.

ADDRESS: (Street and/or PO Box, City, State and Zip Code). This field 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.

PLAN: This field is pre-filled with a description of the product offered. For term products, the level premium period is included in parenthesis. The current range of simplified issue products is:

- Term to Age 80 (5)
- Term to Age 80 (6)
- Term to Age 80 (7)
- Term to Age 80 (10)
- Term to Age 80 (15)
- Term to Age 80 (20)
- Whole Life

These products are our initial planned portfolio of simplified issue life products, and are subject to approval. We certify that only approved products will be marketed. An updated memorandum of variable material will be filed with an updated range with the addition of any new simplified issue life products.

AMOUNT: Based on the Plan shown, the three most popular applied for face amounts (based on experience) will be pre-filled as possible selections. A reasonable range for the displayed amounts, considering the above Plans would be: (Min.) \$2,000 (Max) \$250,000.

Please note that the applicant is able to choose an amount other than those shown by checking the "Other" box, and filling in the desired dollar amount of coverage.

AUTOMATIC PREMIUM LOAN PROVISION REQUESTED: This field is only applicable to Whole Life products. When the Plan solicited is a Term product, the "No" checkbox will be pre-filled. When the Plan solicited is a Whole Life product, both checkboxes will be open, allowing the applicant to choose.

PAYMENT SELECTION – This section will be pre-filled with options in relation to the solicitation channel (i.e. Direct Mailing, Banks)

For Bank Solicitation, the following language will appear:

"I understand that by signing this application, I authorize my premiums to be automatically deducted from my (insert Bank name) account once the policy is issued. All premiums for this coverage will be automatically deducted monthly from my account until I instruct otherwise."

For Credit Card Solicitation, the following language will appear:

"I understand that by signing this application, I authorize my premiums to be automatically charged to my (insert credit card name) account once the policy is issued. All premiums for this coverage will be automatically charged monthly to my account, subject to credit approval, until I instruct otherwise."



MEMORANDUM OF VARIABLE MATERIAL for 10291 (continued)

For broad market solicitations (those other than banks) the following selections will appear:

1. Automatic monthly deductions from my checking or savings account. (Enclose a number deposit slip or voided check.)
2. Charge monthly premiums to my: (checkboxes for each) Visa, MasterCard, Discover (and fields for credit card number and expiration date).
3. Bill me. (Send no money now.)

CONSUMER DISCLOSURE STATEMENT – Within the Agreements section, the last statement: “I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.” will only appear for those applications produced for the Bank Solicitation channel. The Consumer Disclosure on the Sale of Insurance is contained on the accompanying letter that is provided with the application when the product is solicited via banks and states the following:

-Not Insured by FDIC

-Not a Deposit of or Guaranteed by (Bank Name) or any Federal Government Agency or any (Bank Name) Affiliates.

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.

Get a Fast Quote page

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address <https://devlaccess.anico.com/gslife/anicoirectpos/initProc.dhtml?proc=fastQuote&ogn=gsl> Go Links Convert Select

HELPING YOU GET THE MOST OUT OF LIFE

ANICO DIRECT
A Division of American National Insurance Company

ABOUT US FAQ PRIVACY CONTACT US

Get A FastQuote
All asterisked * fields must be completed.

First Name: * Middle Initial: Last Name: *

Suffix:

Primary Mailing Address: *

City: * State: *

Zip: * -

Gender: * Male Female

Date of Birth: * / /

E-Mail Address: *

Work Telephone Number: - - Home Telephone Number: - -

Have you smoked cigarettes in the last 12 months? *

Coverage Amount * (in whole dollars)

Get Quote!

digicert SECURED ssl certificates

1-800-635-8565

DISCOVER MasterCard VISA PayPal

Underwritten by AMERICAN NATIONAL

Done Trusted sites

Suffix: I, II, III, IV, V, Jr., Sr.

State: All 50 states including D.C.

Date of Birth: Month: January – December; Days: 1 – 31; Year: 1924 – 2010

Smoked Cigarettes: Yes or No

Applicant Information page

American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicodeirectpos/processCallCenterThirdPage.dhtml> Go Links Convert Select

HELPING YOU GET THE MOST OUT OF LIFE

ANICO DIRECT
A Division of American National Insurance Company

ABOUT US | FAQ | PRIVACY | CONTACT US

Applicant Information (Continued)

All asterisked * fields must be completed.

Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly.

Height: * ft. in. Weight: * lbs.

Marital Status:

Place of Birth:

US Citizen: * Yes No

Social Security Number: * - -

Home Phone Number: * - -

Occupation: *

Source of Income: *

Household Income: *

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

*** 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:**

• Stroke	• Alzheimer's or hospitalized for any mental or nervous system disorder
• TIA	• Blood or immune system disease (excluding a positive HIV test)
• Heart or circulatory system disease	• Cancer (excluding basal and squamous cell skin cancer)
• Alcoholism or alcohol or drug abuse	• Kidney, liver, pancreas, or lung disease (excluding asthma and bronchitis)
• Attempted suicide	

Yes No

Done Trusted sites

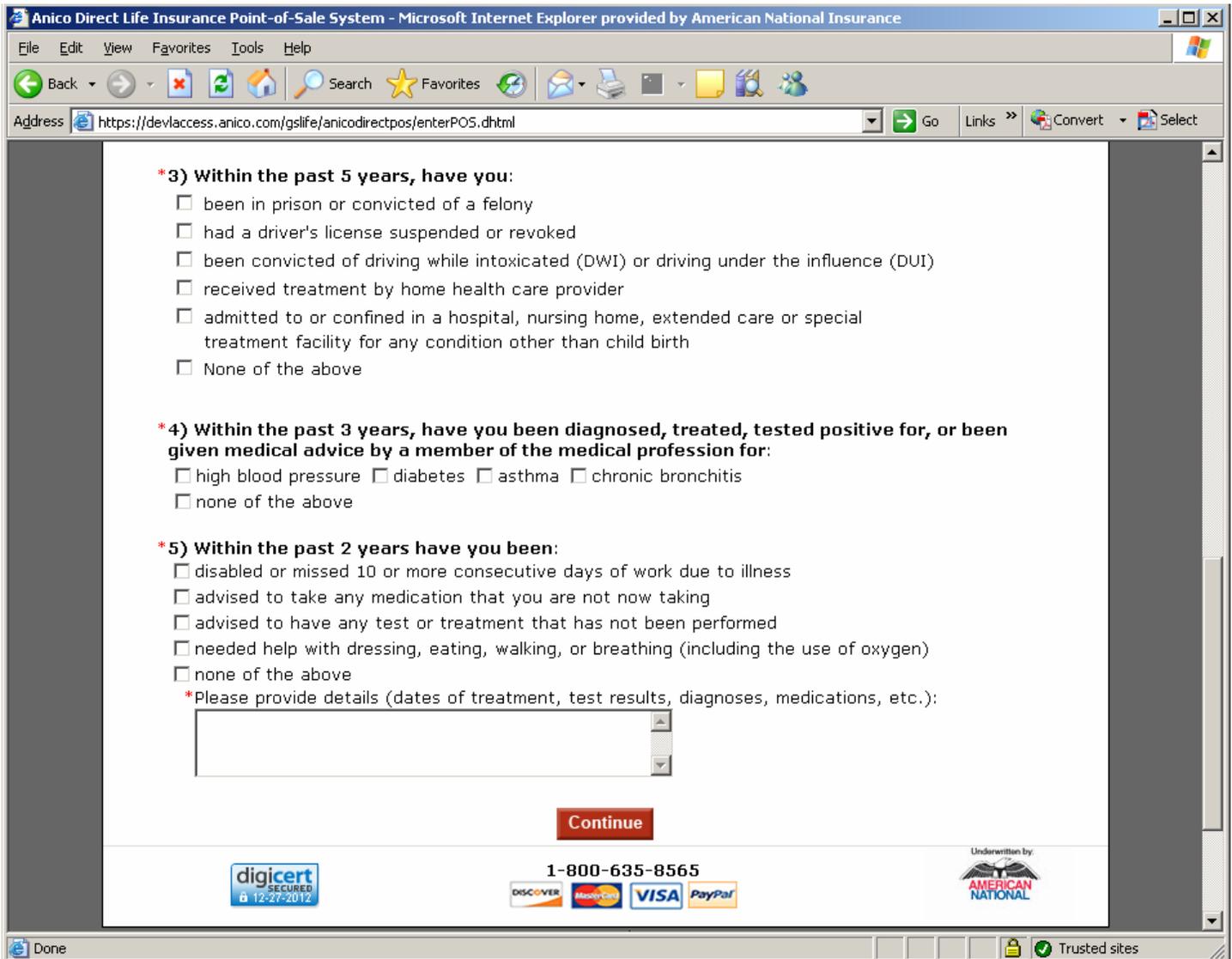
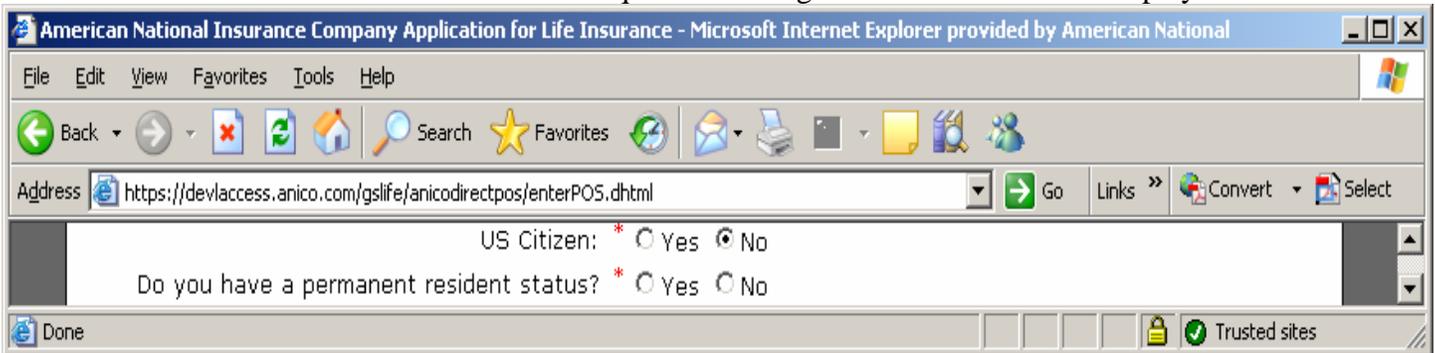
Marital Status: Divorced, Separated, Married, Single, Widowed

Place of Birth: All 50 states including D.C. and "Other"

Occupation: Active Military, Astronaut, Auto Racing, Boat Racing, Coal Mining, Disabled, Early Retirement, Entertainer, Escort, Handling of Explosives, Housewife, Motorcycle Racing, Mountain Climbing, Off Shore Oil or Gas Rigs, Pilot, Professional Diving, Professional Driver, Rodeo Performer, Structural Steel Erection, Student, Stunt Person, Test Pilot, Unemployed, Other

Income: Less than \$10,000, \$10,000-\$24,999, \$25,000-\$49,999, \$50,000-\$99,999, \$100,000 UP

If "US Citizen" is answered "No" an additional question asking their resident status is displayed.



If the applicant is declined based on the answers to the medical questions this screen will display

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Back Forward Stop Home Search Favorites Refresh Print Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/continueOnAfterApplicationReview.dhtml> Go Links Convert Select

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We're sorry, based on the information provided, the application process can not be completed online. If you would like to submit an application for consideration, please click on the "Print Application" below, complete the application, make sure it's signed by the applicant, and mail it to:

American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

 Note: You **MUST** have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain a FREE copy.

Click here to "[Print Application](#)"

Close

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High Blood Pressure page is displayed when high blood pressure is selected on Applicant Information page

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Address <https://devlaccess.anico.com/gslife/anicoirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

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1) When was your high blood pressure first diagnosed? / /

Within the last five (5) years, have you had an

2) electrocardiogram (EKG), cardiac stress test, echocardiogram, Yes No
or other heart or blood vessel study completed?

Other than monitoring, has any treatment or medication been

3) prescribed or recommended as a result of the tests in Yes No
question 2?

How many days have you lost from work or been unable

4) to perform your usual daily activities due to high blood
pressure within the last two (2) years?

5) What was the date and reading of / Reading:
your last blood pressure test? /

Within the last six (6) months has your blood pressure

6) exceeded either 160 systolic (the upper number) or 100 Yes No
diastolic (the lower number)?

7) What is the name and address (city/state) of the medical professional you consult for high blood
pressure?
Name of medical professional: City: State:

8) When did you last visit this medical professional? Month: / Year:

9) What medications have been prescribed for
treatment of your high blood pressure?

10) Are there any medications above that you are not currently taking? Yes No

If Yes, what medications:

Back **Continue**

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Month: January - December

Day: 1 - 31

Year: 1924 - 2010

State: All 50 states including D.C.

Diabetes page is displayed when diabetes is selected on Applicant Information page

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1. Date diabetes diagnosed by a member of the medical profession? / /

2. Type of treatment? Insulin Oral Medication Diet only
Type of insulin and/or oral medication:
Dosage and frequency:

3. Do you follow a diabetic diet? Yes No

4. Have you had any fasting blood sugars performed in the past six (6) months? Yes No
If Yes, results:

5. Results and date of your most recent Hgh A1c (glycosylated hemoglobin), if known:

6. How often do you test your blood for glucose?

7. Since your treatment began, have you ever had a diabetic coma or insulin shock? Yes No
If Yes, when?

8. Within the last twelve (12) months have you been diagnosed by a member of the medical profession of any skin infections or skin ulcers or ever had any amputations? Yes No
If Yes, explain:

9. Do you have any visual problems (other than corrective lenses), heart or circulatory problems, albumin or protein in your urine, loss of consciousness, or numbness or tingling in your feet or legs? Yes No
If Yes, explain:

10. How many days have you lost from work due to diabetes in the last two (2) years?
If any time off from work was due to diabetes in the past two (2) years, provide details including dates and duration of time off from work:

11. Name, address, and phone number of the doctor or clinic supervising your treatment:

Date of last consultation?

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Month: January - December

Day: 1 - 31

Year: 1924 - 2010

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Asthma page is displayed when asthma or chronic bronchitis is selected on Applicant Information page

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All asterisked * fields must be completed.

Asthma Questionnaire

1. a) Do you have, or have you ever had: bronchitis asthma emphysema chronic cough
 wheezing chronic obstructive pulmonary disease pneumonia shortness of breath
 other (explain)

b) Is the cause known?

2. How often do attacks occur and the duration

3. Date of last attack? / /

4. Are the attacks: Mild Moderate Severe

5. Indicate pattern of your attacks in the past five (5) years: no change in symptoms improvement in symptoms
 increasing symptoms or more severe attacks

6. Have you lost time from work? Yes No

If Yes, when, how long, and why?

7. Have you been hospitalized in the last five (5) years for respiratory disorder? Yes No

If Yes

Hospital	City, State & Zip	Approximate date(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Provide the name(s) of the medication(s) or type of treatment you take for your respiratory disorder

Name, address, and phone number of primary physician for respiratory condition:

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Month: January - December

Day: 1 - 31

Year: 1924 - 2010

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Name, address, and phone number of primary physician for respiratory condition:

9. Have pulmonary function studies and tests been performed? Yes No
 If Yes, date and results:

10. Do you use tobacco in any form? Yes No
 If Yes, date and results:
 If used in the past and quit, number of years, quantity and date of last use.

11. Do you use supplemental oxygen? Yes No

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If Replacement of Insurance is selected this page will display.

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Applicant Information (Continued)
 All asterisked * fields must be completed.

Please provide information about the life insurance company that issued the policy or annuity you wish to replace:

Life Insurance Company Name: *

Policy or Contract Number: *

Coverage Amount: *

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Beneficiary Information page

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Applicant Information (Continued)
All asterisked * fields must be completed.

Beneficiary Information:
(If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate)

First Name: Middle Initial: Last Name:

Suffix:

Relationship:

Additional Beneficiary Information:

Back Continue

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Suffix: I, II, III, IV, V, Jr., Sr.

Relationship: Son, Daughter, Brother, Father, Sister, Father-in-law, Brother-in-law, Sister-in-law, Grandson, Granddaughter, Mother, Niece, Nephew, Other, Spouse, Child, Parent, Mother-in-law, Estate, Fiance

If "other" is selected for beneficiary a new field will appear asking for explanation of the insurable interest

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Applicant Information (Continued)
All asterisked * fields must be completed.

Beneficiary Information:
(If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate)

First Name: * Middle Initial: Last Name: *

Suffix:

Relationship: * Other Please Explain Insurable Interest: *

Additional Beneficiary Information:

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Review App/Proposed Insured page

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Have a Question? Email Us! Click Here

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Please make sure the information you provided on your application is accurate by using the "Click here to review your application" link below. Your application will appear on a separate screen. If you need to make corrections, simply close the application screen to return to this page. Then use [this link](#) to make your corrections. Once you are satisfied that all the information is correct, simply click the "Continue" buttons to proceed.

 Note: You **MUST** have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain a FREE copy.

Failure to provide complete and accurate answers to the questions on the application may result in loss of insurance coverage or denial of a claim.

Is the person completing this application the proposed insured? * Yes No

Click [here](#) to review your application.

Back **Continue**

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If "No" is selected this page is displayed

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We're sorry, based on the information provided, the application process can not be completed online. If you would like to submit an application for consideration, please click on the "Print Application" below, complete the application, make sure it's signed by the applicant, and mail it to:

American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

 Note: You **MUST** have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain a FREE copy.

[Click here to "Print Application"](#)

[Close](#)

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If “this link” is clicked from “Review App/Proposed Insured page” then this page is loaded.
Change of Address Information page

The screenshot shows a Microsoft Internet Explorer browser window displaying the American National Insurance Company application page. The browser's address bar shows the URL: <https://devlaccess.anico.com/gslife/anicodeirectpos/continueOnAfterApplicationReview.dhtml>. The page header features the ANICO DIRECT logo and the tagline "HELPING YOU GET THE MOST OUT OF LIFE". Below the header is a navigation menu with links for "About Us", "FAQ", "Privacy", and "Contact Us". The main content area is titled "Change of address information" and contains a form with the following fields:

- Salutation: *
- First Name: * Middle Initial: Last Name: *
- Suffix:
- Primary Mailing Address: *
- City: * State: TX Zip: * -
- Work Telephone Number: - - Home Telephone Number: * - -

At the bottom of the form are two buttons: "Back" and "Continue". The footer includes a "digicert SECURED" logo, the phone number "1-800-635-8565", and logos for Discover, MasterCard, VISA, and PayPal. The page is underwritten by American National Insurance Company.

Salutation: Dr., Mr., Mrs., Ms

Suffix: I, II, III, IV, V, Jr., Sr.

Notice of Insurance Information Practices Disclosure

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Notice of Insurance Information Practices

You have now provided the personal information needed to evaluate your insurance application. Before we can complete your application review, we must ask you to read and accept certain disclosures about our information practices and provide us with any necessary authorizations. These disclosures begin below.

Exchange of Information Notice

We are required to provide you the following disclosures to you:

Medical Information Bureau, Inc. (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. American National Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential.

You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA PATRIOT Act Notice

The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

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Back Forward Stop Home Search Favorites Refresh Print Stop Convert Select

Address <https://devlaccess.anico.com/gslife/anicodeirectpos/continueOnAfterApplicationReview.dhtml> Go Links >> Convert Select

I have read the information above.

Click [here](#) to print for your records.

Continue

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Consent for Use of Electronic Signatures and Records Disclosure page

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Back Forward Stop Home Search Favorites Refresh Print Mail Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/verifyACH.dhtml> Go Links Convert Select

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Consent For Use Of Electronic Signatures and Records - Before we can process your application online, we will need you to sign it together with certain other documents. This process will bind your electronic "signature" to these documents such that no changes can ever be made to the information you provided without invalidating your signature. This provides you with the assurance that any information you provide will be retained exactly as you provided it - guaranteed! Also, please be assured that all of your information is subject to our strictest security and privacy standards. Click on the Security & Privacy link below for more information. Please read and acknowledge your consent to use electronic signatures and agreement to receive required notices and documents electronically.

Consent for use of electronic signatures and records:

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application ("Required Information"). With your consent, American National Insurance Company can deliver Required Information to you by: Displaying or delivering the Required Information electronically, and Requesting that you print or download the Required Information and retain it for your records.

This notice contains important information that you are entitled to receive before you consent to electronic delivery of required information. Your consent also permits the general use of electronic records and electronic signatures in connection with your application. Please read this notice carefully and print or download a copy for your files.

After you have read this information, if you agree to receive Required Information from American National Insurance Company electronically, and if you agree to the general use of electronic records and electronic signatures in connection with your relationship with American National Insurance Company, please click on the "Accept" button at the bottom.

Statement of electronic disclosures:

You may request to receive Required Information on paper, but if you do not consent to electronic delivery of Required Information, American National Insurance Company cannot proceed with the acceptance and processing of your electronic application.

If you consent to electronic delivery of Required Information, you may withdraw that consent at any time. However, if you withdraw your consent we will not be able to continue processing your application.

If you consent to electronic disclosures, that consent applies to all Required Information American National Insurance Company gives you or receives from you in connection with your life insurance application and the associated notices, disclosures, and other documents.

The Required Information that may covered by the consent includes, among other things:

Medical Information Bureau (MIB) Pre- Notice of Insurance Information Practices

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File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites Mail Print Taskbar Start Links Convert Select

Address <https://devlaccess.anico.com/gslife/anicoirectpos/verifyACH.dhtml> Go

Notification

Authorization to release personal health information Notices regarding policy replacement and adverse underwriting decisions

You agree to print out or download Required Information when we advise you to do so and keep it for your records. If you have any trouble printing out or downloading any Required Information, you may call American National Insurance Company at 1-800-638-8565 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time and request paper copies. If you need to update your e-mail address or other contact information with American National Insurance Company, you may do so by calling us at 1-800-638-8565 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the required information via email. Upon receipt, we will update your records.

If you wish to withdraw your consent to electronic disclosures, you may do so by calling us at 1-800-638-8565 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the request via email. After consenting to receive and deliver Required Information electronically, you may, upon request, obtain a paper copy of the Required Information by calling 1-800-638-8565 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time.

Software and Hardware Requirements:

To access and retain Required Information from American National Insurance Company, you must:

1. Be able to view the disclosures on your monitor and send screen prints to your printer, which can be done with your browser.
2. Have access to an Internet service account and use Internet Explorer V4.0 and above or Netscape Navigator V4.x and above to receive required information
3. Be able to send and receive e-mail that contains hyperlinks to Websites in order for American National Insurance Company to deliver required information to you

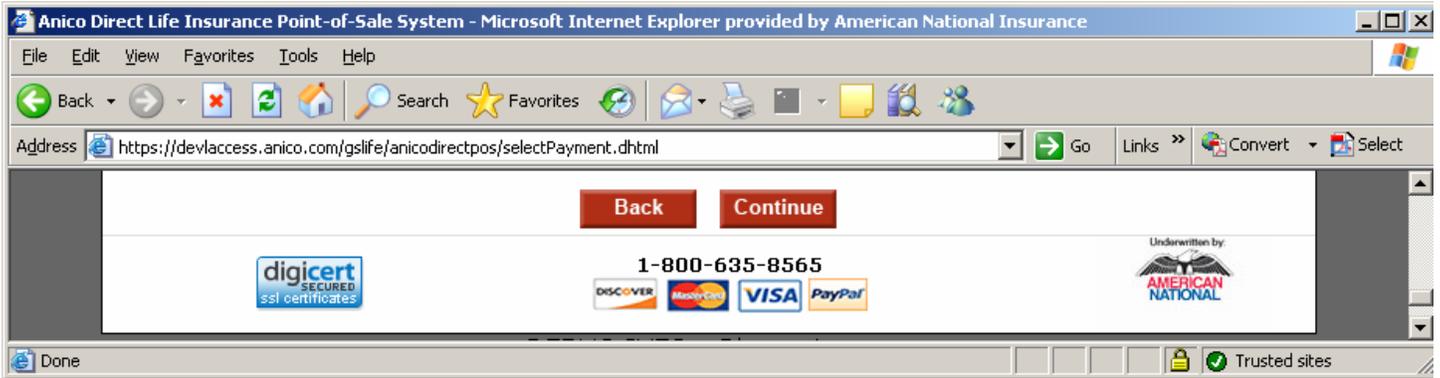
If you do not have the required software and/or hardware, or if you do not wish to use electronic records and signatures for any other reason, you can request paper copies of the application document (s) to be sent to you by clicking on the Contact Us link at the bottom and sending us your request.

Your consent does not mean that American National Insurance Company must provide the Required Information electronically. American National Insurance Company may, at their option, deliver Required Information on paper if it chooses to do so. American National Insurance Company may also require that certain communications from you be delivered to American National Insurance Company on paper at a specified address.

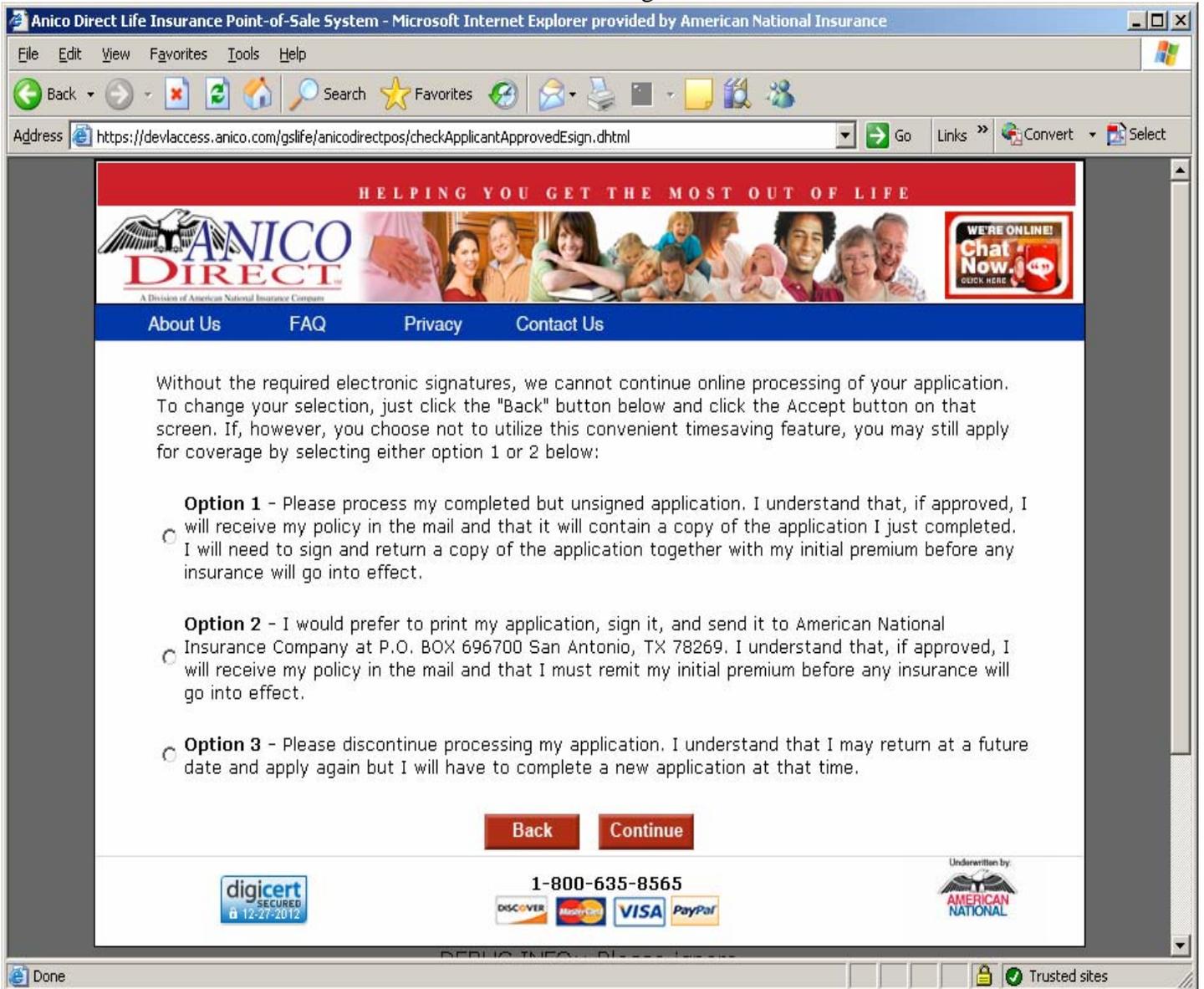
I have read the information about the use of electronic records, disclosures, notices, and e-mail, and consent to the use of electronic records for the delivery of required information in connection with my life insurance application with American National Insurance Company. I have been able to view this information using my computer and software. I have an account with an internet service provider, and I am able to send e-mail and receive e-mail with hyperlinks to websites and attached files. I also consent to the use of electronic records and electronic signatures in connection with my life insurance application with American National Insurance Company in place of written documents and handwritten signatures. I am consenting on behalf of all joint applicants identified in the application. I am authorized to consent on their behalf.

Accept Decline

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If "Decline" is selected to "Consent for Use of Electronic Signatures and Records" disclosure



Option 1

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Application Referred to Underwriter

Thank you for your application. It has been referred to an underwriter for further evaluation. Be assured that nothing will be charged or deducted if you have provided us with your billing information. You will be hearing from us in the next few days regarding the results of the review process.

[Close](#)

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Option 2

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Application Processing Will Be Delayed

Selecting this option will unnecessarily delay providing the financial security this plan offers. If you have questions or concerns, please be sure to review the [FAQ](#) section where we have attempted to address those questions most often asked. If you still decide to continue, we cannot process your signed application until we receive it in the mail.

If you would like us to process your application immediately, please click "Back" and accept E-Signature; otherwise, click "Continue" to proceed.

[Back](#) [Continue](#)

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If Continue is clicked from Option 2

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Address <https://devlaccess.anico.com/gslife/anicodeirectpos/enterImportantReminder.dhtml> Go Links Convert Select

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Important Reminder!

Processing can't begin until we receive your signed application.

 Note: You **MUST** have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain a FREE copy.

Please click "Continue" to see your application. Then review, print, sign, date and mail it to American National Insurance Company at the following address:

American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

Click [here](#) to print the address above for your convenience.

Your application, will be processed immediately upon receipt and, once approved, your policy will be mailed. The next screen will present the application as you've completed it to this point. Please don't delay - print and mail your application today! Thank you for considering American National Insurance Company for your life insurance needs. We look forward to receiving your application soon.

Continue

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Option 3

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Back Forward Stop Home Search Favorites Refresh Print Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/EnterApplicantAnsweredNoToE5ign.dhtml> Go Links Convert Select

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Thank You!

Thank you for considering American National Insurance Company for your life insurance needs. We're sorry we were unable to meet your needs at this time but we hope you will return to our site the next time you consider providing financial security for your family.

Close

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Payment Method Selection page

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Payment Method Selection
All asterisked * fields must be completed.

Your application for **\$75,000 of Level Term 80 - LP20** has been approved for a monthly premium of only **\$19.75**. The next step is to put your coverage into effect by selecting one of the payment options described below.

Remember, by choosing to pay your premiums automatically by any option other than direct bill, and, subject to collection, your coverage can go into effect immediately. Choosing one of those automatic payment options will also save you time, worry and money. The monthly premium of **\$19.75** will be paid on time, every time. You'll save money on postage and check fees, too.

*** Please select a payment method**

Credit Card (\$19.75 monthly)   

PayPal (\$19.75 monthly) 

Automatic Deductions from Your Checking or Savings Account (\$19.75 monthly)

Direct Billing on a monthly, quarterly, semi-annual or annual basis

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If PayPal is selected the customer will be directed into the PayPal site to complete payment.

Credit Card Payment Information page

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Address <https://devlaccess.anico.com/gslife/anicoirectpos/selectPayment.dhtml> Go Links Convert Select

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Credit Card Payment Information

All asterisked * fields must be completed.

Paying your premiums with a credit card is easy and secure. By submitting the following information, you authorize American National Insurance Company to charge your premiums monthly to the credit card indicated below. You understand you can revoke your authorization at any time with written notice to American National Insurance Company.

Insurance Plan: **Level Term 80 - LP20**
Monthly Premium: **\$19.75**

Card Type: *   

Cardholder's Name: *

Card Number: * Security Code:

Expiration Date: * /

Credit Card Billing Address:
(Please make change if necessary)

Street: * City: *

State: * Zip: * -

 1-800-635-8565  Underwritten by 

Done Trusted sites

Card Type: MasterCard, Visa, Discover

Month: January - December

Year: 2010 - 2015

State: All 50 states including D.C.

ACH Payment Information page

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ANICO DIRECT
A Division of American National Insurance Company

ABOUT US FAQ PRIVACY CONTACT US

ACH Payment Information

All asterisked * fields must be completed.

By submitting your nine-digit Routing/Transit Number in field 1 below, your account number in field 2, and the type of account in field 3, you authorize American National Insurance Company to deduct your premiums monthly from the checking or savings account indicated below. You understand you can revoke your authorization at any time with written notice to American National Insurance Company. For an example, please click on the ABA# or Acct#.

Insurance Plan: **Level Term 80 - LP20**
Monthly Premium: **\$19.75**

Account Holder's Name:

Account Holder's Address:

Account Holder's City, State Zip: , -

DATE: [Apr 06, 2010](#)

PAY TO THE ORDER OF American National Insurance Company \$

1. * ABA# 2. * Acct# 3. * Type

Back **Continue**

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DISCOVER MasterCard VISA PayPal

digicert SECURED ssl certificates

Trusted sites

State: All 50 states including D.C.

Type: Checking, Savings

Electronic Review and Signing Process page

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/esign/aws/core/online> Go Links Convert Select

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Electronic Review And Signing Process

You will be prompted to add your electronic signature to the following documents using "CLICK TO SIGN HERE" arrows ([Click Here](#) to see a sample). By clicking on the arrow, you will agree to all the terms and conditions described above the signature or in the document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement.

Please continue by selecting, then reviewing and signing each item listed below. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

DOCUMENT	STATUS
Step 1: Review and Click-to-Sign Contract Documents (1 document(s))	
Application For Individual Life Insurance	Waiting for Signature

Click [here](#) to print for your records.

Continue

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DISCOVER MasterCard VISA PayPal

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Electronic Review And Signing Process

Application For Individual Life Insurance

Please review all information.
You are required to sign in 1 place(s).

D4101059

**APPLICATION FOR
INDIVIDUAL LIFE INSURANCE**

American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

ABOUT YOU

Name: Mr ARAPPSTES TING E-mail: A@A.COM

Address: 501 MAIN ST Apt. _____

City: LITTLE ROCK State: AR ZIP Code: 71601

Social Security Number: 548 - 43 - 1313 Female Male Height: 6 ft. 00 in. Weight: 190

Home Phone: (354) 384 - 3841 Work Phone: (281) 444 - 4444 Household Income: 50K-99K

Date of Birth: 01 / 01 / 1970 Place of Birth: AZ Source of Income: JOB

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: ANALYST

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 (DUI) 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: Level Term 80 - LP20 Amount: \$ \$50,000

Beneficiary: BEN ONE Relationship: Son

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.

Charge my monthly premiums to my Direct Billing

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION AND AGREEMENTS

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 applicant(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 determining 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.

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



Click [here](#) to print for your record.

Back

Continue



1-800-635-8565



Application signed after clicking yellow arrow

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 applicant(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 determining 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.

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

e-Signatures
by Silanis

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ssl certificates

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Electronic Review and Signing Process page, showing all documents are signed

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/esign/aws/core/online> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

Electronic Review And Signing Process

You will be prompted to add your electronic signature to the following documents using "CLICK TO SIGN HERE" arrows ([Click Here](#) to see a sample). By clicking on the arrow, you will agree to all the terms and conditions described above the signature or in the document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement.

Please continue by selecting, then reviewing and signing each item listed below. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

DOCUMENT	STATUS
Step 1: Review and Click-to-Sign Contract Documents (1 document(s))	
Application For Individual Life Insurance	Signed ✓

Click [here](#) to print for your records.

Continue

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DISCOVER MasterCard VISA PayPal

digicert SECURED 12-27-2012

Done Trusted sites

If the application is referred to an underwriter this page will load

The screenshot shows a Microsoft Internet Explorer browser window. The title bar reads "Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance". The address bar contains the URL "https://devlaccess.anico.com/gslife/anicoirectpos/handleESignOnlineHandback.dhtml". The page content includes a red header with the slogan "HELPING YOU GET THE MOST OUT OF LIFE" and the "ANICO DIRECT" logo. Below the header is a navigation menu with "About Us", "FAQ", "Privacy", and "Contact Us". The main heading is "Application Referred to Underwriter". The text below reads: "Thank you for your application. It has been referred to an underwriter for further evaluation. Be assured that nothing will be charged or deducted if you have provided us with your billing information. You will be hearing from us in the next few days regarding the results of the review process." A red "Close" button is centered below the text. At the bottom, there are logos for "digicert SECURED 12-27-2012", "1-800-635-8565", and payment methods including DISCOVER, MasterCard, VISA, and PayPal. The "Underwritten by AMERICAN NATIONAL" logo is also present.

If the application is free from issues and the payment method is direct bill this page will display.

The screenshot shows a Microsoft Internet Explorer browser window with the same title and address as the previous image. The page content is identical to the first screenshot, but the main heading is "Thank You For Applying Online!". The text below reads: "Thank you for completing American National Insurance Company's online application process. Your bill and policy will be mailed to you and you can expect to receive it in 5 to 7 days." It continues: "Please email us using the [contact us](#) link above to let us know if the process met your expectations and how we might improve it in the future." and "Once again, welcome to our family of thousands of satisfied American National Insurance Company customers. We appreciate the opportunity you have given us to assist in providing for your financial security and will do our best to earn your trust." A "Click [here](#) to print for your records." link is centered below the text. A red "Close" button is centered below the text. The footer contains the same logos as the first screenshot: "digicert SECURED 12-27-2012", "1-800-635-8565", payment methods (DISCOVER, MasterCard, VISA, PayPal), and "Underwritten by AMERICAN NATIONAL".

If the application is free from issues and payment has been received by either credit card, ACH or PayPal this page will display along with the customer's new policy number.

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites RSS Print Mail Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/handleESignOnlineHandback.dhtml> Go Links Convert Select

HELPING YOU GET THE MOST OUT OF LIFE

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A Division of American National Insurance Company

ABOUT US FAQ PRIVACY CONTACT US

Thank You For Your Insurance Purchase!

Thank you for completing American National Insurance Company's online application process. Subject to collection of your credit card payment, your coverage is now in effect. Your policy will be mailed to you and you can expect to receive it in 5 to 7 days. For your records, your policy number is **D4100930**. Please make note of this number for future reference.

Please email us using the [contact us](#) link above to let us know if the process met your expectations and how we might improve it in the future.

Once again, welcome to our family of thousands of satisfied American National Insurance Company customers. We appreciate the opportunity you have given us to assist in providing for your financial security and will do our best to earn your trust.

Close

1-800-635-8565

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Get a Fast Quote page

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites Print Mail Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/initProc.dhtml?proc=fastQuote&agentId=s0014&ogn=insurancecol> Go Links Convert Select

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A Division of American National Insurance Company

ABOUT US FAQ PRIVACY CONTACT US

Get A FastQuote
All asterisked * fields must be completed.

Promotion Name: *

State of Residence: *

Date of Birth: * / /

Gender: * Male Female

Have you smoked cigarettes *
in the last 12 months?

Coverage Amount *
(in whole dollars)

Get Quote!

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1-800-635-8565

digicert SECURED 12-27-2012

DISCOVER MasterCard VISA PayPal

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Promotion Name: Company marketing promotions

State: All 50 states including D.C.

Date of Birth: Month: January – December; Days: 1 – 31; Year: 1924 – 2010

Smoked Cigarettes: Yes or No

Your Personalized Fast Quote page

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites Mail Print

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processCallCenterSecondPage.dhtml> Go Links Convert Select

HELPING YOU GET THE MOST OUT OF LIFE



[About Us](#) [FAQ](#) [Privacy](#) [Contact Us](#)

Your Personalized FastQuote!

All asterisked * fields must be completed.

Based on the information you provided, you are eligible to apply for:

*Insurance Plan	Coverage Amount	Monthly Premium	Cash Values After		
			5 Yrs	10 Yrs	20 Yrs
<input checked="" type="radio"/> BudgetGuard term - 7 year level premium	\$250,000	\$39.00	N/A	N/A	N/A
<input type="radio"/> BudgetGuard term - 15 year level premium	\$250,000	\$59.00	N/A	N/A	N/A
<input type="radio"/> BudgetGuard term - 20 year level premium	\$250,000	\$81.50	N/A	N/A	N/A

If you would like another quote, Please enter another Coverage Amount (in whole dollars): [New Quote](#) Or [Apply Now!](#)

[Back](#)

[Refuse](#)

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Get a Fast Quote page (cont)

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processCallCenterSecondPage.dhtml> Go Links Convert Select

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Get A FastQuote

All asterisked * fields must be completed.

First Name: * Middle Initial: Last Name: *

Suffix:

Primary Mailing Address: *

City: * State: *

Zip: * -

E-Mail Address:

Work Telephone Number: - - Home Telephone Number: - -

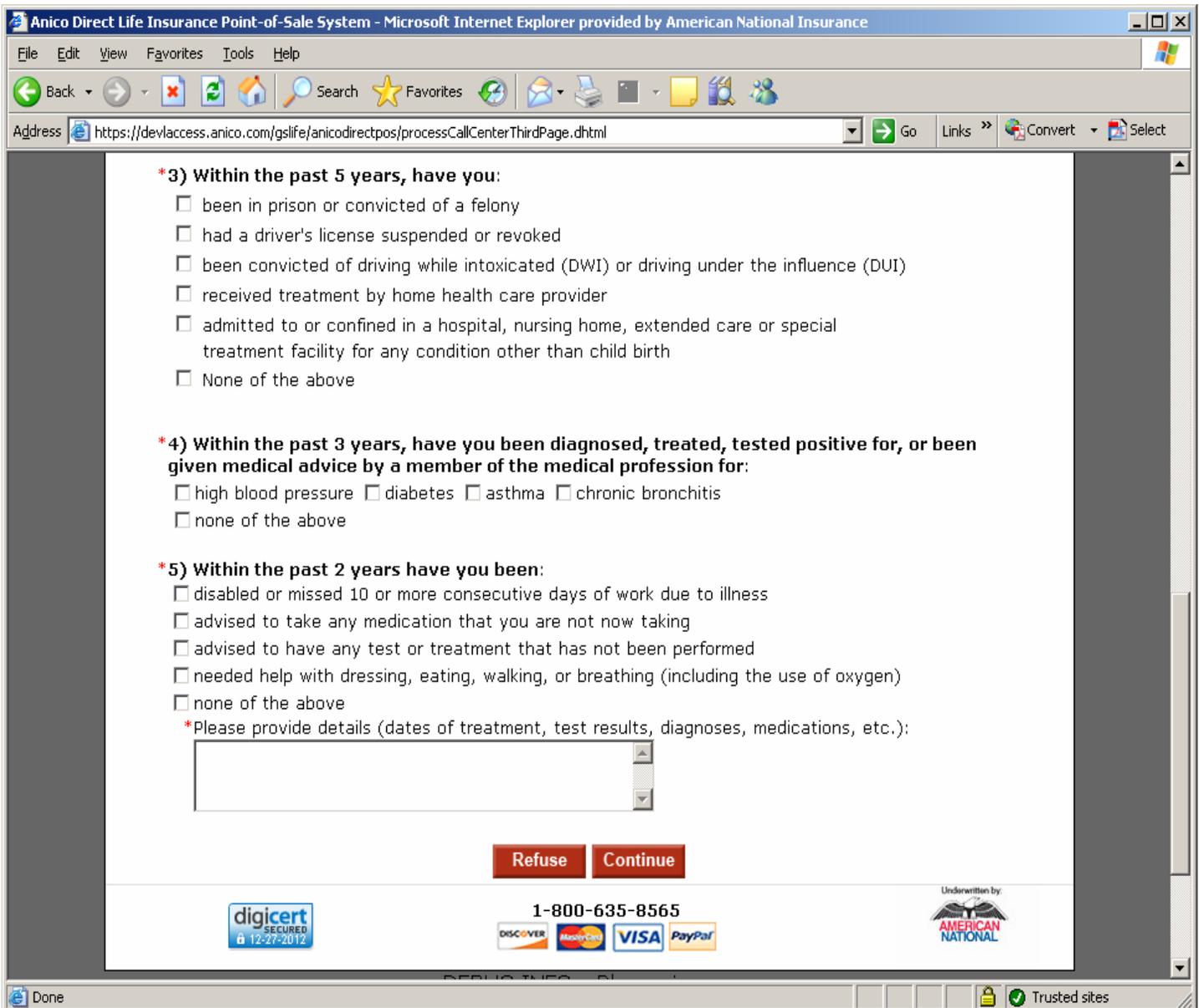
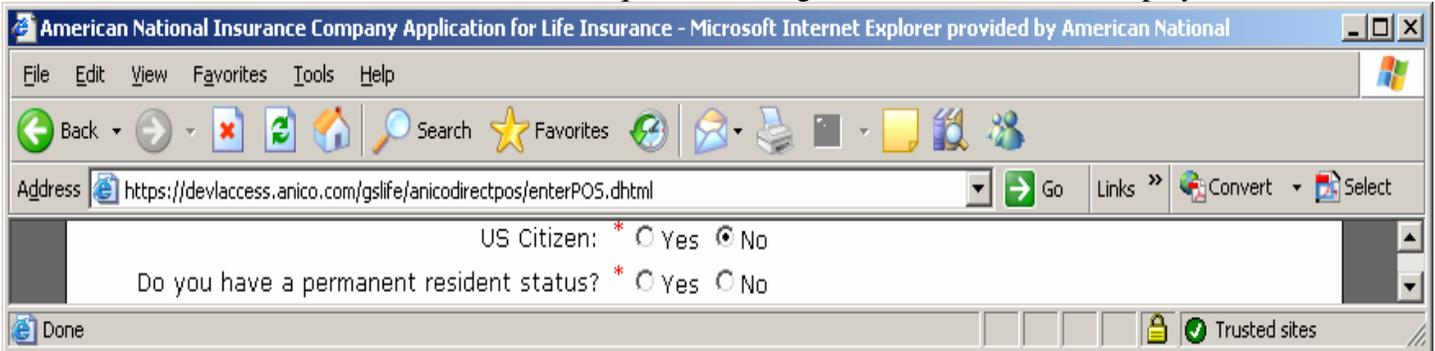
 1-800-635-8565     Underwritten by 

Done Trusted sites

Suffix: I, II, III, IV, V, Jr., Sr.

State: All 50 states including D.C.

If "US Citizen" is answered "No" an additional question asking their resident status is displayed.



If the applicant is declined based on the answers to the medical questions this screen will display

The screenshot shows a Microsoft Internet Explorer browser window. The title bar reads "American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National". The address bar contains the URL "https://devlaccess.anico.com/gslife/anicoirectpos/continueOnAfterApplicationReview.dhtml". The browser's menu bar includes "File", "Edit", "View", "Favorites", "Tools", and "Help". The toolbar contains icons for Back, Forward, Stop, Home, Search, Favorites, Refresh, Print, and other functions. The main content area features a red banner with the text "HELPING YOU GET THE MOST OUT OF LIFE" and the "ANICO DIRECT" logo. Below the banner is a navigation menu with "About Us", "FAQ", "Privacy", and "Contact Us". The central message states: "I'm sorry that we will be unable to process your application today. Thank you for considering American National Insurance Company for your life insurance needs. Goodbye." A red "Close" button is positioned below the message. At the bottom of the page, there are logos for "digicert SECURED 12-27-2012", "1-800-635-8565", and logos for "DISCOVER", "MasterCard", "VISA", and "PayPal". The footer also includes "Underwritten by AMERICAN NATIONAL" and a "Trusted sites" icon in the status bar.

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicoirectpos/continueOnAfterApplicationReview.dhtml> Go Links Convert Select

HELPING YOU GET THE MOST OUT OF LIFE

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A Division of American National Insurance Company

ABOUT US FAQ PRIVACY CONTACT US

I'm sorry that we will be unable to process your application today. Thank you for considering American National Insurance Company for your life insurance needs. Goodbye.

Close

1-800-635-8565

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digicert SECURED 12-27-2012

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High Blood Pressure page is displayed when high blood pressure is selected on Applicant Information page

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

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1) When was your high blood pressure first diagnosed? / /

2) Within the last five (5) years, have you had an electrocardiogram (EKG), cardiac stress test, echocardiogram, or other heart or blood vessel study completed? Yes No

3) Other than monitoring, has any treatment or medication been prescribed or recommended as a result of the tests in question 2? Yes No

4) How many days have you lost from work or been unable to perform your usual daily activities due to high blood pressure within the last two (2) years?

5) What was the date and reading of your last blood pressure test? / / Reading:

6) Within the last six (6) months has your blood pressure exceeded either 160 systolic (the upper number) or 100 diastolic (the lower number)? Yes No

7) What is the name and address (city/state) of the medical professional you consult for high blood pressure?
Name of medical professional: City: State:

8) When did you last visit this medical professional? Month: / Year:

9) What medications have been prescribed for treatment of your high blood pressure?

10) Are there any medications above that you are not currently taking? Yes No

If Yes, what medications:

Refuse **Back** **Continue**

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Month: January - December

Day: 1 - 31

Year: 1924 - 2010

State: All 50 states including D.C.

Asthma page is displayed when asthma or chronic bronchitis is selected on Applicant Information page

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

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All asterisked * fields must be completed.

Asthma Questionnaire

1. a) Do you have, or have you ever had: bronchitis asthma emphysema chronic cough
 wheezing chronic obstructive pulmonary disease pneumonia shortness of breath
 other (explain)

b) Is the cause known?

2. How often do attacks occur and the duration

3. Date of last attack? / /

4. Are the attacks: Mild Moderate Severe

5. Indicate pattern of your attacks in the past five (5) years: no change in symptoms improvement in symptoms
 increasing symptoms or more severe attacks

6. Have you lost time from work? Yes No

If Yes, when, how long, and why?

7. Have you been hospitalized in the last five (5) years for respiratory disorder? Yes No

If Yes

Hospital	City, State & Zip	Approximate date(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Provide the name(s) of the medication(s) or type of treatment you take for your respiratory disorder

Name, address, and phone number of primary physician for respiratory condition:

Done Trusted sites

Month: January - December

Day: 1 - 31

Year: 1924 - 2010

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites Print Mail Stop Taskbar

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

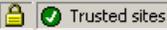
9. Have pulmonary function studies and tests been performed? Yes No
If Yes, date and results:

10. Do you use tobacco in any form? Yes No
If Yes, date and results:
If used in the past and quit, number of years, quantity and date of last use.

11. Do you use supplemental oxygen? Yes No

[Refuse](#) [Back](#) [Continue](#)

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Done 

Diabetes page is displayed when diabetes is selected on Applicant Information page.

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

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1. Date diabetes diagnosed by a member of the medical profession? / /

2. Type of treatment? Insulin Oral Medication Diet only
Type of insulin and/or oral medication:
Dosage and frequency:

3. Do you follow a diabetic diet? Yes No

4. Have you had any fasting blood sugars performed in the past six (6) months? Yes No
If Yes, results:

5. Results and date of your most recent Hgh A1c (glycosylated hemoglobin), if known:

6. How often do you test your blood for glucose?

7. Since your treatment began, have you ever had a diabetic coma or insulin shock? Yes No
If Yes, when?

8. Within the last twelve (12) months have you been diagnosed by a member of the medical profession of any skin infections or skin ulcers or ever had any amputations? Yes No
If Yes, explain:

9. Do you have any visual problems (other than corrective lenses), heart or circulatory problems, albumin or protein in your urine, loss of consciousness, or numbness or tingling in your feet or legs? Yes No
If Yes, explain:

10. How many days have you lost from work due to diabetes in the last two (2) years?
If any time off from work was due to diabetes in the past two (2) years, provide details including dates and duration of time off from work:

11. Name, address, and phone number of the doctor or clinic supervising your treatment:

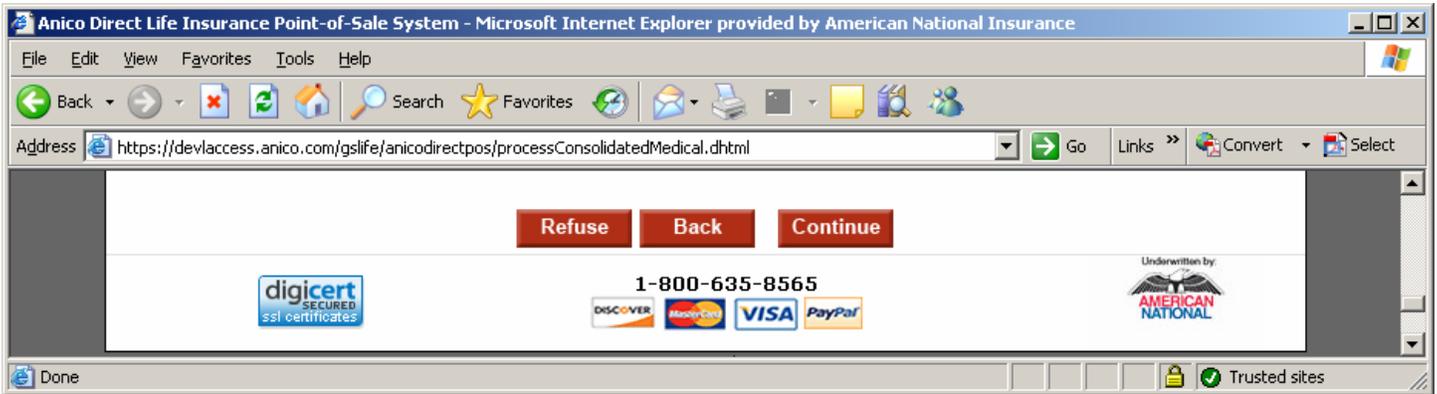
Date of last consultation?

Done Trusted sites

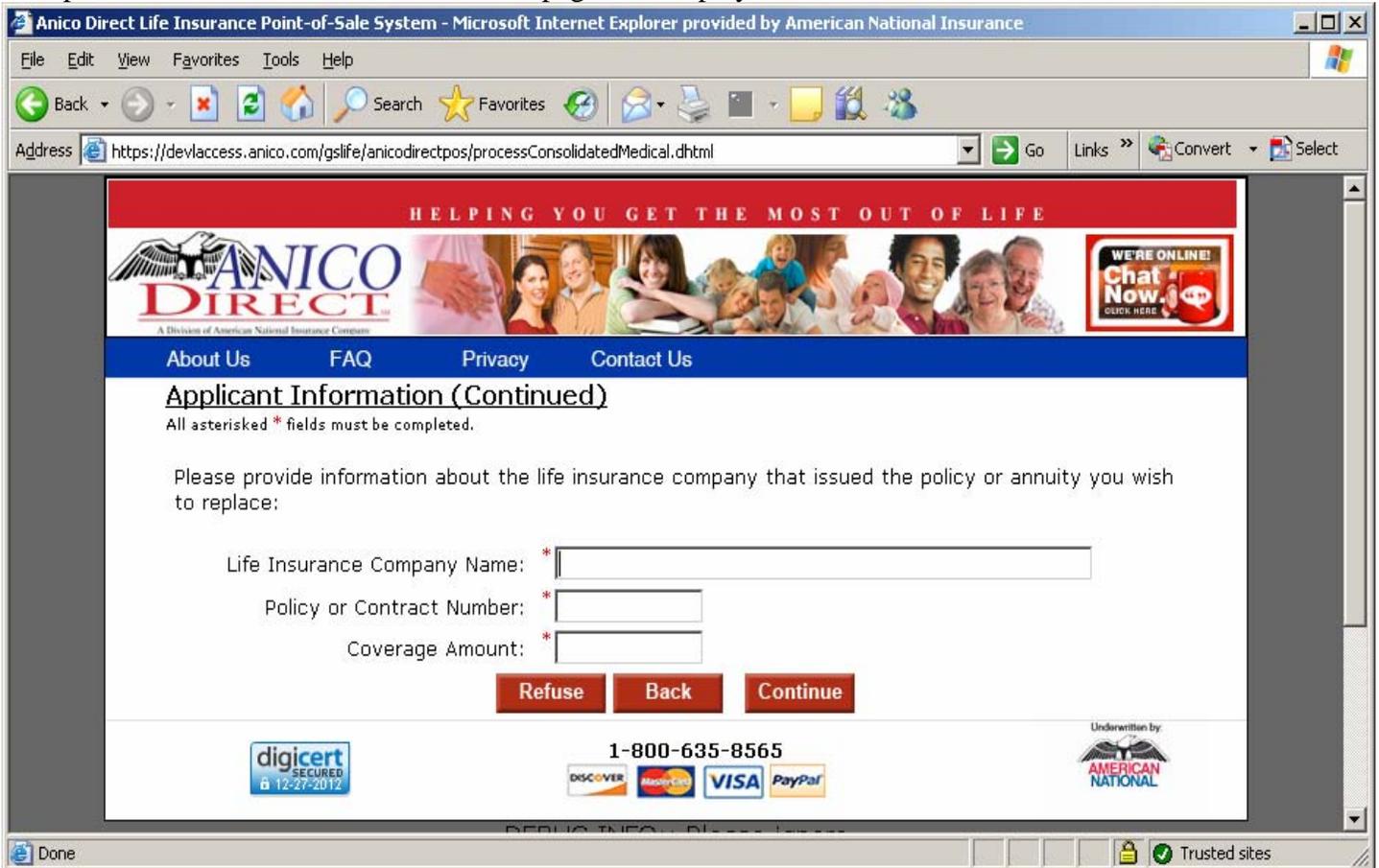
Month: January - December

Day: 1 - 31

Year: 1924 - 2010



If Replacement of Insurance is selected this page will display.



Beneficiary Information page

American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Mail Print Address Bar

Address <https://devlaccess.anico.com/gslife/anicodeirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

Applicant Information (Continued)
All asterisked * fields must be completed.

Beneficiary Information:
(If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate)

First Name: Middle Initial: Last Name:

Suffix:

Relationship:

Additional Beneficiary Information:

Refuse Back Continue

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Done Trusted sites

Suffix: I, II, III, IV, V, Jr., Sr.

Relationship: Son, Daughter, Brother, Father, Sister, Father-in-law, Brother-in-law, Sister-in-law, Grandson, Granddaughter, Mother, Niece, Nephew, Other, Spouse, Child, Parent, Mother-in-law, Estate, Fiance

If "other" is selected for beneficiary a new field will appear asking for explanation of the insurable interest

American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address <https://devlaccess.anico.com/gslife/anicodeirectpos/processConsolidatedMedical.dhtml> Go Links Convert Select

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A Division of American National Insurance Company

ABOUT US | FAQ | PRIVACY | CONTACT US

Applicant Information (Continued)
All asterisked * fields must be completed.

Beneficiary Information:
(If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate)

First Name: * Middle Initial: Last Name: *

Suffix:

Relationship: * Other Please Explain Insurable Interest: *

Additional Beneficiary Information:

Refuse **Back** **Continue**

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Proposed Insured page

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/processConsolidatedSupp.dhtml> Go Links Convert Select

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About Us FAQ Privacy Contact Us

The answers you provided will be recorded on your application which will be included in your policy when it is delivered. Please review the application carefully and call American National Insurance Company if there are any errors.

Failure to provide complete and accurate answers to the questions on the application may result in loss of insurance coverage or denial of a claim.

Are you the proposed insured? * Yes No

Refuse Back Continue

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If "No" is selected this page will display

The screenshot shows a Microsoft Internet Explorer browser window. The title bar reads "American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National". The address bar contains the URL: <https://devlaccess.anico.com/gslife/anicoirectpos/continueOnAfterApplicationReview.dhtml>. The browser interface includes a menu bar (File, Edit, View, Favorites, Tools, Help) and a toolbar with icons for Back, Forward, Stop, Home, Search, Favorites, Refresh, Print, and other functions. The main content area features a red banner with the text "HELPING YOU GET THE MOST OUT OF LIFE" and the "ANICO DIRECT" logo, which is a division of American National Insurance Company. Below the banner is a navigation menu with links for "About Us", "FAQ", "Privacy", and "Contact Us". The central message states: "I'm sorry that we will be unable to process your application today. Thank you for considering American National Insurance Company for your life insurance needs. Goodbye." A red "Close" button is positioned below the message. At the bottom of the page, there are logos for "digicert SECURED 12-27-2012", "1-800-635-8565", and payment logos for Discover, MasterCard, VISA, and PayPal. The American National logo is also present, with the text "Underwritten by AMERICAN NATIONAL". The browser's status bar at the bottom right shows a "Trusted sites" icon.

Notice of Insurance Information Practices Disclosure

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicoirectpos/continueOnAfterApplicationReview.dhtml> Go Links Convert Select

HELPING YOU GET THE MOST OUT OF LIFE

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About Us FAQ Privacy Contact Us

Notice of Insurance Information Practices
Exchange of Information Notice

Please play the recording for the customer.

By acknowledging that this information has been disclosed to you - please state, "I Agree"

Refuse Continue

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By checking the box above the database is updated with a “yes” that the customer has accepted the disclosure.

Please see “Disclosure Scripts.doc” for details on recording.

“Consent for Use of Electronic Signatures and Records” disclosure page

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A Division of American National Insurance Company

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About Us FAQ Privacy Contact Us

Consent For Use Of Electronic Signatures and Records

Please play the recording for the customer.

By acknowledging that this information has been disclosed to you - please state, "I Agree"

Refuse **Back** **Continue**

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By checking the box above the database is updated with a “yes” that the customer has accepted the disclosure.
Please see “Disclosure Scripts.doc” for details on recording.

Payment Method Selection page

American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites

Address <https://devlaccess.anico.com/gslife/anicodeirectpos/checkApplicantApprovedEsign.dhtml> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

Payment Method Selection

All asterisked * fields must be completed.

You can choose to pay your premiums by either credit card or automatic deductions from your checking or savings account. Which would you prefer?

*** Please select a payment method**

- Credit Card (\$109.00 monthly) 
- Automatic Deductions from Your Checking or Savings Account (\$109.00 monthly)
- Direct Billing on a monthly, quarterly, semi-annual or annual basis

Refuse Back Continue

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Done Trusted sites

Credit Card Payment Information page

American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Stop

Address <https://devlaccess.anico.com/gslife/anicoirectpos/selectPayment.dhtml> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

Credit Card Payment Information

All asterisked * fields must be completed.

Paying your premiums with a credit card is easy and secure. By submitting the following information, you authorize American National Insurance Company to charge your premiums monthly to the credit card indicated below. You understand you can revoke your authorization at any time with written notice to American National Insurance Company.

Insurance Plan: **Level Term 80 - LP15**
Monthly Premium: **\$16.00**

Card Type:   

Cardholder's Name:

Card Number: Security Code:

Expiration Date: /

Credit Card Billing Address:
(Please make change if necessary)

Street: City:

State: Zip: -

 **1-800-635-8565**     Underwritten by 

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Card Type: MasterCard, Visa, Discover

Month: January - December

Year: 2010 - 2015

State: All 50 states including D.C.

ACH Payment Information page

American National Insurance Company Application for Life Insurance - Microsoft Internet Explorer provided by American National

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Mail Print Address Bar

Address <https://devlaccess.anico.com/gslife/anicoirectpos/selectPayment.dhtml> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

ACH Payment Information

All asterisked * fields must be completed.

By submitting this information, you are authorizing American National Insurance Company to deduct your premiums monthly from your account. You can revoke your authorization at any time with written notice to American National Insurance Company .

Insurance Plan: **Level Term 80 - LP15**
Monthly Premium: **\$16.00**

Account Holder's Name:
Account Holder's Address:
Account Holder's City, State Zip: , -

DATE: [Apr 14, 2010](#)

PAY TO THE ORDER OF American National Insurance Company \$

1. * ABA# 2. * Acct# 3. * Type

Refuse Back Continue

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1-800-635-8565

DISCOVER MasterCard VISA PayPal

Underwritten by: **AMERICAN NATIONAL**

DERUG INFO: Please ignore

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State: All 50 states including D.C.

Type: Checking, Savings

“Application” disclosure page

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Consent to Agreements and Representations

Please play the recording about Agreements and Representations.

Refuse Back Continue

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Please see “Disclosure Scripts.doc” for details on recording.

Electronic Review and Signing Process page

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/esign/aws/core/online> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

Electronic Review And Signing Process

You will be prompted to add your electronic signature to the following documents using "CLICK TO SIGN HERE" arrows ([Click Here](#) to see a sample). By clicking on the arrow, you will agree to all the terms and conditions described above the signature or in the document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement.

Please continue by selecting, then reviewing and signing each item listed below. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

DOCUMENT	STATUS
Step 1: Review and Click-to-Sign Contract Documents (1 document(s))	
Application For Individual Life Insurance	Waiting for Signature

Click [here](#) to print for your records.

Continue

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Anico Direct Life Insurance - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Mail Print

Address <https://devlaccess.anico.com/esign/aws/core/online> Go Links Convert Select

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HAVE A QUESTION?

Email Us!

CLICK HERE

[About Us](#) [FAQ](#) [Privacy](#) [Contact Us](#)

Electronic Review And Signing Process

Application For Individual Life Insurance

Please review all information.
You are required to sign in 1 place(s).

D4101060



**APPLICATION FOR
INDIVIDUAL LIFE INSURANCE**

American National Insurance Company
 P.O. BOX 696700
 San Antonio, TX 78269

ABOUT YOU

Name: Mr CLLNTRSITE ARAPPTST E-mail: A@A.COM

Address: 501 MAIN ST Apt. _____

City: LITTLE ROCK State: AR ZIP Code: 71601

Social Security Number: 434 - 38 - 3488 Female Male Height: 6 ft. 00 in. Weight: 190

Home Phone: (281) 555 - 5555 Work Phone: (281) 444 - 4444 Household Income: 50K-99K

Date of Birth: 01/01/1970 Place of Birth: AZ Source of Income: JOB

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: ANALYST

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: Level Term 80 - LP15 Amount: \$ \$50,000

Beneficiary: BEN ONE Relationship: Son

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.

Charge my monthly premiums to my Direct Billing

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION AND AGREEMENTS

Done Trusted sites

AR App (cont)

CLICK TO SIGN HERE

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 applicant(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 determining 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.

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 : _____ Date X ____/____/____

10291-AR

Click [here](#) to print for your record.

Decline **Back** **Continue**

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If "Decline" is clicked on the e-sign app page

Microsoft Internet Explorer

Are you sure you want to exit signing the application and discontinue the process? If you would like to continue with the application process click Cancel otherwise click OK to exit.

OK Cancel

AR App e-signed

Anico Direct Life Insurance - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address https://devlaccess.anico.com/esign/aws/core/online#awsApprovalBlock1_231887_10291-AR_APPapproval Go Links Convert Select

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 applicant(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 determining 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.

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 : Date X / /

10291-AR



✓ SIGNED

e-Signature
by Silanis

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Decline **Back** **Continue**

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This page shows that the app was signed.

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/esign/aws/core/online> Go Links Convert Select

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Have a Question? **Email Us!** [CLICK HERE](#)

About Us FAQ Privacy Contact Us

Electronic Review And Signing Process

You will be prompted to add your electronic signature to the following documents using "CLICK TO SIGN HERE" arrows ([Click Here](#) to see a sample). By clicking on the arrow, you will agree to all the terms and conditions described above the signature or in the document. This will result in an enforceable legal document, just as if you had signed your name to a paper agreement.

Please continue by selecting, then reviewing and signing each item listed below. Failure to sign all of the items will result in our being unable to process your application online. You will still be eligible for this valuable coverage but we will have to delay the start until we can complete all of the requirements by mail.

DOCUMENT	STATUS
Step 1: Review and Click-to-Sign Contract Documents (1 document(s))	
Application For Individual Life Insurance	Signed ✓

Click [here](#) to print for your records.

Continue

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If the application is referred to an underwriter this page will display.

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address <https://devlaccess.anico.com/gslife/anicoirectpos/handleESignOnlineHandback.dhtml> Go Links Convert Select

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Application Referred to Underwriter

Thank you for your application. It has been referred to an underwriter for further evaluation. Be assured that nothing will be charged or deducted if you have provided us with your billing information. You will be hearing from us in the next few days regarding the results of the review process.

Close

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12-12

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If the application is free from issues this page will display

Anico Direct Life Insurance Point-of-Sale System - Microsoft Internet Explorer provided by American National Insurance

File Edit View Favorites Tools Help

Address <https://devlaccess.anico.com/gslife/anicoirectpos/handleESignOnlineHandback.dhtml> Go Links Convert Select

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ABOUT US FAQ PRIVACY CONTACT US

Thank You For Your Insurance Purchase!

Thank you for completing American National Insurance Company's online application process. Subject to collection of your credit card payment, your coverage is now in effect. Your policy will be mailed to you and you can expect to receive it in 5 to 7 days. For your records, your policy number is **D4100930**. Please make note of this number for future reference.

Please email us using the [contact us](#) link above to let us know if the process met your expectations and how we might improve it in the future.

Once again, welcome to our family of thousands of satisfied American National Insurance Company customers. We appreciate the opportunity you have given us to assist in providing for your financial security and will do our best to earn your trust.

Close

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Exchange of Information, Medical Information Bureau, Inc. Pre-notifications, Fair Credit Reporting Act and USA Patriot Act Notices: -

Exchange of Information Notice

We are required to provide the following disclosures to you:

Medical Information Bureau, Inc. (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. American National Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB 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 about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential. You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA Patriot Act Notice

The USA Patriot Act requires that we establish an Anti-Money Laundering ("AML") Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

By acknowledging that this information has been disclosed to you – please state, "I Agree".

Consent for use of electronic signatures and records:

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application. This part of the notice requires you to consent to the use of electronic signatures in connection with your application. This consent will allow the representative to electronically sign on your behalf, the application documents for which you have just provided information. Even if you consent to use electronic signatures, paper copies of the application documents will be sent to you with your policy for your review. If you consent to the use of electronic signatures in place of handwritten signatures as just stated, please say "I AGREE".

AR

Authorization to obtain, release and disclose medical information and agreements

You 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. You understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations. You understand: a) such information will be used by ANICO for underwriting and insurability decisions; b) You may refuse to sign this authorization and that your refusal will affect your 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) You may inspect or copy any information used or disclosed under this authorization; g) and you may revoke the authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: American National Insurance Company P.O. BOX 696700 San Antonio, TX 78269. You have received the Exchange of Information Notice.

You declare that the answers and statements to the questions above are complete and true to the best of your knowledge and belief. You understand and agree: that the answers and statements will be relied upon by ANICO in determining 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 you; and the first premium due is paid in full while you are alive and in the same health condition as described here.

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.

In order for us to ensure your understanding and to obtain your authorization and agreement to what has just been read to you, please say "I accept"

ANICO Direct Processes:

As a Direct Marketing division, we send Direct Marketing solicitations to perspective clients through direct mail and email/banner ads.

Email/Banner ad process:

- The primary path for the customer is to click on the link within the email to enter ANICO Direct's website where if they make a decision to receive a rate quote they proceed to the customer portal.
- The secondary path for the customer is to call on the phone number that is provided within the email or website. There, they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

Direct Mail process:

- The primary path for the customer is to fill out the application and send it to American National for processing.
- As a secondary path, the customer is provided with a URL within the letter; the URL allows the customer to go to ANICO Direct's website where if they make a decision to receive a rate quote, they proceed to the customer portal.
- An additional secondary path is that the customer is also provided with the call center phone number, where they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

The tools used to complete the process online is either a Call Center portal (completed by our call center agents) or the Customer path (completed by the customer applying for the product).

Call Center portal:

- When a customer calls our call center, we have the ability to help them by taking them through the Path which we refer to as the call center portal. In order to write the business for the customer, the agent must be licensed in that state. Within the portal, there is a validation against the licensing system to validate the licensing.
- The process is tailored for the agent to read the questions and disclosures on the screen as a script, with the customers consent to complete the process on their behalf.
- The process also has embedded recordings, since disclosures can be state specific, the portal uses the insured state to queue the appropriate recording to ensure consistency with the disclosures.
- Once the questions, disclosures, and payment method have been completed, the application is generated in Silanes for an e-signature process. The e-signature process is approved by the customer and recorded for validation with a process called CVR (Continuous Voice Recording). The e-signature process is a secured signature process confirming acknowledgement of the application.
- CVR records the entire conversation through a vendor called Verint. The database is completely secured with read-only access to the data base to pull the recordings for review. In order to easily identify the recording, the agent "tags" the conversation with software called TagIt. The policy number is entered into TagIt to identify the recording.

Customer portal:

- The customer receives a rate quote on the system and if they proceed, will be asked a series of medical questions and are presented with disclosures to read. Their responses are saved to a database that is later used to populate the application for signature.
- Once the questions, disclosures, and payment method have been completed, the application is generated in Silanes for an e-signature process. The e-signature process is approved and completed by the customer.

All policies written through the tools above are sent to the administration system for processing.

Administration:

- Once the case is assigned a policy number and signed, the case is sent to the Administration system that will process the application. The final disposition of the case is determined and correspondence is sent from that system. The final correspondence will either be a bill and policy or a decline letter.



APPLICATION FOR INDIVIDUAL LIFE INSURANCE

American National Insurance Company P.O. BOX 696700 San Antonio, TX 78269

ABOUT YOU

Name: Ms Linda Davis E-mail: na@na.com
Address: 27 Main Ave Apt.
City: Arkansas State: AR ZIP Code: 72201
Social Security Number: 797 - 97 - 9797 [X] Female [] Male Height: 5 ft. 02 in. Weight: 145
Home Phone: (281) 999 - 9999 Work Phone: (409) 999 - 9999 Household Income: 25k-49K
Date of Birth: 04/ 04 / 1975 Place of Birth: AR Source of Income: admin assistant
Marital Status: [X] Married [] Divorced [] Single [] Widowed [] Separated
Are you a U.S. Citizen? [X] Yes [] No If 'No', do you have a permanent resident status? [] Yes [] No
Have you smoked cigarettes in the last 12 months? [] Yes [X] No Occupation: admin assistant

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 [X] 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 [X] 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 [X] 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 [X] 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 [X] No

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Level Term 80 - LP10 Amount: \$ \$45,000
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 [X] No
Do you intend to replace, discontinue, or change any existing life insurance policy? [] Yes [X] 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.
Charge my monthly premiums to my Master Card

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 determining 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.

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 Linda Davis Date 03 31 2010

Experian Result Report

Policy Number: D4100885

Date: Mar 31, 2010

Name: Ms Linda Davis

Experian Score: 0

Audit Number:

Level One Response

Address Verification:

Address Type:

Address High Risk:

Change of Address:

Phone Verification:

Phone High Risk:

SSN:

OFAC:

Date of Birth Match Codes:

May 5, 2010

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

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
Online and Telephone application procedures for previously approved
ICC1010291 – Application for Individual Life Insurance
SERFF Tracking Number: AMNA-126473289
State Tracking Number: 44732
Company Tracking Number: AD-SI APP

Dear Reviewer:

Please find that the original filing has been amended and procedures for our electronic (online) and telephone application process have been added.

There are two sets of screens – one is used directly by the applicant online, the other is used by a telephone agent when the applicant contacts our call center to apply via telephone. Each set is titled appropriately and attached under the Supporting Documentation tab as a separate item.

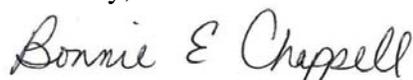
For the telephone process, there is also a set of disclosures. As you review the screens for the telephone process, you will see (towards the end) where there are audio recordings to play. The disclosure document identifies what is prerecorded and played to the applicant over the phone.

Because the online and telephone processes follow the same general flow, only one example of the completed application is necessary. The example has also been attached as a separate item under the Supporting Documentation tab.

Lastly, to aid in the understanding of our processes for each, a document explaining the overall process has been provided and attached under the Supporting Documentation tab.

Our records indicate there is no filing fee. Should this be incorrect, please let us know.

Sincerely,



Bonnie E. Chappell
Senior Compliance Analyst

BEC/

Enclosures