

SERFF Tracking Number: AMNA-126645344 State: Arkansas
Filing Company: American National Insurance Company State Tracking Number: 46076
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.201 Early Duration Reduced Benefit - Level
Premium - Any Policy Design
Product Name: AD - GBL
Project Name/Number: /

Filing at a Glance

Company: American National Insurance Company

Product Name: AD - GBL SERFF Tr Num: AMNA-126645344 State: Arkansas
TOI: L071 Individual Life - Whole SERFF Status: Closed-Withdrawn State Tr Num: 46076
Sub-TOI: L071.201 Early Duration Reduced Benefit - Level Premium - Any Policy Design Co Tr Num: State Status: Withdrawn
Filing Type: Form Reviewer(s): Linda Bird
Author: Tyra Reed Disposition Date: 07/22/2010
Date Submitted: 06/28/2010 Disposition Status: Withdrawn
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized
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: 07/22/2010 Explanation for Other Group Market Type:
State Status Changed: 07/22/2010
Deemer Date: Created By: Tyra Reed
Submitted By: Tyra Reed Corresponding Filing Tracking Number:
Filing Description:
RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:
Form GBL10(10) iV Individual Whole Life Insurance Policy
Form GBL10DM-DP iV Specifications Page used with Form GBL10(10)
10301-01 iV Application for Individual Graded Benefit Whole Life Insurance Policy
SERFF Tracking Number: AMNA-126645344
Company Tracking Number: AD-GBL

Dear Reviewer:

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

Form GBL10(10) is an individual whole life insurance policy with fixed premiums payable until the Insured's attained age 121. Policy loans are available up to the total amount of the policy's cash value. The policy contains nonforfeiture options for, paid-up insurance and cash surrender. This whole life policy offers a reduced death benefit if death occurs from illness or other natural causes within the first two policy years. This reduced death benefit is equal to 110% of premiums due and paid. If death within the first two policy years is due to accidental bodily injury, the death benefit is the full face amount. Beginning in policy year three, the death benefit is equal to the full face amount regardless of the cause of death.

Form GLB10DM-DP v is the specifications page that will be used in conjunction with policy Form GBL10(10) for direct solicitation. The direct solicitation version:

- „X issue age range of minimum 50 and maximum 80
- „X is available on a sex distinct basis
- „X has a minimum face amount of \$3,000 and a maximum face amount of \$25,000
- „X issuance of the policy is accepted based on the statements regarding the applicant's current health within the application
- „X is issued on an individual basis
- „X is not illustrated

10301-01 is the application form used in direct solicitation scenarios. The recognized market where this application will be used is: direct mail and bank market. Applicants may also apply for this product via internet or by calling the telephone number provided in the mailed solicitation. Each process (online and telephone) uses an online process which walks the applicant through the application process. Screen prints for both processes are attached to the Supporting Documentation tab.

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

- „X Statement of Variability for the policy form, data page, and application
- „X Actuarial Memorandum
- „X Certification of Compliance
- „X Payment of the required filing fee in the amount of \$ 75.00 has been submitted via EFT
- „X Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.
- „X As the above listed products are issued on a sex-distinct basis, we confirm that the policy(ies) will not be issued in any employer-employee plans that are subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.

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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

Fee Required? Yes
 Fee Amount: \$75.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	\$75.00	06/28/2010	37612162
American National Insurance Company	\$75.00	07/09/2010	37845392

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Linda Bird	07/22/2010	07/22/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	07/21/2010	07/21/2010	Tyra Reed	07/21/2010	07/21/2010
Pending Industry Response	Linda Bird	07/12/2010	07/12/2010	Tyra Reed	07/20/2010	07/20/2010
Pending Industry Response	Linda Bird	06/29/2010	06/29/2010	Tyra Reed	07/09/2010	07/09/2010

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Disposition

Disposition Date: 07/22/2010

Implementation Date:

Status: Withdrawn

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Screen Prints - Online and Telephone Process		Yes
Supporting Document	Statement of Variability		Yes
Form	Individual Whole Life Insurance Policy		Yes
Form	Specifications Page used with Form GBL10(10)		Yes
Form	Application for Individual Graded Benefit Whole Life Insurance Policy		Yes

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Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 07/21/2010
Submitted Date 07/21/2010
Respond By Date 08/23/2010

Dear Tyra Reed,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: The policy form GBL10(10) is in violation of both Arkansas Bulletin 8-85 Guideline One and Two of this Bulletin. Please review Bulletin 8-85. The Actuarial Memorandum states "For the first two years the death benefit is 110% of premiums paid". The death benefit will need to be a set dollar amount or % of the face amount for the first two policy years. The death benefit can not be a return of premium with or without interest.

Bulletin 8-85 Guideline Two states "While accidental death benefits, appropriately rated, may be added by rider in the same manner as they are with other life insurance policies, the inclusion of an accidental death benefit to be in effect only during the period of reduced benefits (e.g., in lieu of the reduced benefit or in such amount as to increase the total benefit to that payable after the period of reduced benefits), is misleading and appears to contray to Ark. Stat. Ann. s66-3323(1)(b). Such provisions will not be approved".

Please feel free to contact me if you have questions.

Sincerely,
Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/21/2010
Submitted Date 07/21/2010

Dear Linda Bird,

Comments:

Thank you for your feedback.

At this time we request to withdraw the filing. We will work on addressing the requirements under Bulletin 8-85. This will require some re-work of items outside the policy form. We will submit a new filing at that time.

Thanks again!

Response 1

Comments: Request to withdraw.

Related Objection 1

Comment:

The policy form GBL10(10) is in violation of both Arkansas Bulletin 8-85 Guideline One and Two of this Bulletin. Please review Bulletin 8-85. The Actuarial Memorandum states "For the first two years the death benefit is 110% of premiums paid". The death benefit will need to be a set dollar amount or % of the face amount for the first two policy years. The death benefit can not be a return of premium with or without interest.

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Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

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No Rate/Rule Schedule items changed.

Sincerely,
Tyra Reed

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 07/12/2010
Submitted Date 07/12/2010
Respond By Date 08/12/2010

Dear Tyra Reed,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Life Policies with reduced death benefits in early policy years are subject to Bulletin 8-85. The contract is in violation of both Guideline One and Two of this bulletin.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/20/2010
Submitted Date 07/20/2010

Dear Linda Bird,

Comments:

Thank you for your comments regarding this submission.

Response 1

Comments: For the disclosure required in Guideline One, I have added a disclosure to the face page of the policy, which clearly explains the amounts payable under the policy.

For Guideline Two - can you please expand on your comment regarding the accidental death benefit? Our intent is to pay the Ultimate Face Amount as the death benefit during policy years 1 and 2 as long as death was from accidental reasons, with the exception of the common exclusions listed in the policy form.

We have had states request/require that certain exclusions be removed or revised, but none have requested that the accidental death benefit provision be removed entirely.

Related Objection 1

Comment:

Life Policies with reduced death benefits in early policy years are subject to Bulletin 8-85. The contract is in violation of both Guideline One and Two of this bulletin.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If the revised policy form continues to violate 8-85, please advise and we will continue to work to bring it into compliance.

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Your continued review and advisement is greatly appreciated!

Sincerely,
Tyra Reed

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/29/2010
Submitted Date 06/29/2010
Respond By Date 07/29/2010

Dear Tyra Reed,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$75.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/09/2010
Submitted Date 07/09/2010

Dear Linda Bird,

Comments:

Response 1

Comments: Please find that the additional fee has been submitted.

Thank you for bringing this item to our attention!

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$75.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Tyra Reed

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	Form GBL10(10)	Policy/Contract/Fraternal Certificate Individual Whole Life Insurance Policy	Initial		56.700	Form GBL10(10).pdf
	Form GBL10DM-DP	Data/Declaration Pages used with Form GBL10(10)	Initial		52.700	Form GBL10DM-DP.pdf
	10301-01	Advertising Application for Individual Graded Benefit Whole Life Insurance Policy	Initial		51.800	10301-01.pdf



AMERICAN NATIONAL INSURANCE COMPANY
A STOCK LIFE INSURANCE COMPANY

POLICY NUMBER [12345678] [JOHN INSURED] INSURED
ISSUE DATE [JANUARY 1, 2010] \$ [20,000] ULTIMATE FACE AMOUNT

HOME OFFICE: [ONE MOODY PLAZA, GALVESTON TX 77550]
ADMINISTRATIVE OFFICE: [ONE MOODY PLAZA, GALVESTON TX 77550]
TELEPHONE NUMBER [(409) 763-4661]

This telephone number is available for Policyholders to make inquiries or obtain information about coverage and provide assistance in resolving complaints.

AMERICAN NATIONAL INSURANCE COMPANY ("We", "Us", "Our") will pay the Death Benefit to the Beneficiary subject to the provisions of this Policy. The Death Benefit is payable upon receipt at Our Home Office in Galveston, Texas of due Proof of Death of the Insured. This Policy is issued in consideration of the Application and payment of the Premiums as described within the Policy. This Policy is a legal contract between the Owner ("You", "Your") and Us. **READ YOUR POLICY CAREFULLY.**

RIGHT TO EXAMINE. [You may cancel this Policy for any reason within 30 days after its receipt. You must mail or deliver the Policy to Our Home Office. Any premiums paid, including any Policy Fee or other charges will be refunded to You. The Policy will then be treated as if it were never issued.]

Signed at Our Home Office at [Galveston, TX] on the Issue Date.

[]

[J. Mark Flippin]
[Secretary]

[]

[G. R. Ferdinandtsen]
[President]

INDIVIDUAL WHOLE LIFE INSURANCE POLICY

- Premium Paying Period as shown on the Data Page
 - Nonparticipating. Dividends are not payable.
 - Death Benefit is reduced if death of the Insured occurs within the first two Policy Years.
 - Death Benefit payable in lump sum or as described in the Settlement Options provision.
 - This Policy is a Modified Endowment Contract
-

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ALPHABETICAL GUIDE TO POLICY PROVISIONS

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Additional benefits and riders (if any), a copy of the Application and any supplements are attached to this Policy.

CONTRACT AND INTERESTED PERSONS

ENTIRE CONTRACT – This Policy, any endorsements, and the attached Application form the Entire Contract. All statements in the Application, in the absence of fraud, will be deemed representations and not warranties. No statement will be used to contest the Policy or be used in defense of a claim under it unless:

- (a) it is contained in the written Application for the Policy; and
- (b) a copy of the Application is attached to the Policy at the Issue Date or upon Reinstatement.

EFFECTIVE DATE – This Policy takes effect on the Issue Date shown or as soon thereafter as the initial premium has been received at Our Home Office and the Policy has been delivered to You during the Insured's lifetime and same health as stated on the Application.

OWNER – The Owner ("You", "Your") is named on the Data Page. If the Owner is a partnership, the rights belong to the partnership as it exists when a right is exercised. Before Termination of the Policy, as stated in the Termination provision, You may exercise the rights of ownership given by this Policy.

If You are a minor, first the Insured, then the Beneficiary, if living and legally competent, may exercise all rights of ownership. If You die while the Insured is living, ownership will pass to the contingent owner if one is named. If there is no contingent owner, ownership will pass to the Owner's estate. All rights of the Owner, the contingent owner, and the Beneficiary are secondary to the rights of:

- (a) any Assignee of record; and
- (b) any Irrevocable Beneficiary.

The Owner may change the ownership of the Policy by written request. The change shall take effect on the date the request was signed, unless otherwise specified by the Owner, subject to any payments made or actions taken by Us prior to the receipt of such request.

INSURED - The person on whose death the Death Benefit will be paid and who is named as such on the Data Page. The Insured has no Ownership rights under this Policy unless the Owner and the Insured is the same person or unless the Owner is not legally competent.

BENEFICIARY - The Beneficiary is the person named to receive the Death Benefit of this Policy in the event of the Insured's death. The initial Beneficiary is designated in the Application. If changed, the Beneficiary is the person named on the most current written request to change the Beneficiary filed and recorded by Us.

BENEFICIARY INTEREST - Beneficiaries will be designated as primary (first) or contingent (secondary). All Beneficiaries named as primary or first are in one class. Those named as contingent or secondary are in a different class and will not share in the proceeds of a death claim unless no Beneficiary named as primary survives the Insured as described below. All relationships are in reference to the Insured.

Unless changed by endorsement or written request filed at Our Home Office:

- (a) two or more class members of the same class will share proceeds equally;
- (b) surviving class members will share equally the proceeds to which a deceased Beneficiary would have been entitled; and
- (c) if no Beneficiary survives the Insured, proceeds will be paid to the Owner's estate.

A Beneficiary will not share in any proceeds or benefits if:

- (a) the Beneficiary dies within 30 days after the Insured's Death; and
- (b) Our Home Office has not received Proof of Death of the Insured.

If the Beneficiary is not a Natural Person, the Beneficiary must still exist at the time of the Insured's death. All Beneficiaries' interests are secondary to any Assignment on record at the Home Office.

CHANGE OF BENEFICIARY – If there is no Assignee or Irrevocable Beneficiary, You may change a Beneficiary by filing a written request in a form acceptable to Us at our Home Office. A change will not take effect until We receive Your written request and record the change at the Home Office. Once recorded, the change will be effective as of the date You signed the request. The change is subject to:

- (a) the rights of any Assignee on record; and
- (b) the rights of an Irrevocable Beneficiary.

IRREVOCABLE BENEFICIARY – A permanent Beneficiary whose rights under the Policy cannot be changed without his or her consent. The consent of the Irrevocable Beneficiary must be in writing.

ASSIGNEE – This Policy may be assigned or pledged to a Natural Person or a legal entity as security for a debt. The Assignee's rights under this Policy will supersede those of the Beneficiary and the Owner.

DEFINITION OF TERMS

APPLICATION – The Application includes the document so labeled and any Supplemental Applications, Reinstatement Applications, or Applications for any riders or additional benefits.

ATTAINED AGE – The Insured's age at issue plus the number of Policy Years completed.

MODIFIED ENDOWMENT CONTRACT – Is a policy where the Premiums paid exceed the 7 Pay Premium as defined in Section 7702A of the Internal Revenue Code. A Modified Endowment Contract will still qualify for income-tax-free treatment of the Death Benefit, but may result in the loss of favorable tax treatment and possible penalties on Loans or the Cash Surrender of this Policy.

NATURAL PERSON – A human being only and not a trust, a corporation, or any other legally recognized entity.

PAYEE – A person to whom any of the proceeds of the Policy are payable.

POLICY DEBT – The total of all unpaid Loans plus unpaid interest on the Loans.

POLICY MONTH – The first Policy Month begins on the Issue Date and ends on the day preceding the same date in the next calendar month. Each succeeding Policy Month begins on the same date of each calendar month. This date is also referred to as the monthly anniversary.

POLICY YEAR – The period beginning on the Issue Date and ending one year later and each succeeding one year period.

PROOF OF DEATH – Includes all of the following:

- (a) a certified death certificate of the Insured or other lawful evidence providing equivalent information;
- (b) a claimant statement;
- (c) the Policy; and
- (d) any other information We may reasonably require to establish the validity of the claim.

GENERAL PROVISIONS

CONFORMITY WITH STATE LAW - This Policy is subject to the laws of the jurisdiction where it is delivered. If any provision of this Policy is contrary to any such law, such provision is amended to conform to the minimum standards of such law.

NONPARTICIPATING POLICY – This Policy is nonparticipating. It does not share in Our profits or surplus.

INCONTESTABILITY – This Policy will be incontestable after it has been in force during the Insured's lifetime for 2 years from the Issue Date, except for nonpayment of Premium and except as to any provision or condition relating to disability benefits or additional benefits for accidental death, which may be contested at any time.

A Reinstatement shall be incontestable after it has been in force during the Insured's lifetime for 2 years after the date of Reinstatement, except as to any nonpayment of Premium and except as to any provision or condition relating to disability benefits or additional benefits for accidental death, which may be contested at any time.

We may only contest this Policy under this provision based on material misstatements or omissions in the Application, Supplemental Application, or Reinstatement Application.

SUICIDE – If the Insured, whether sane or insane, dies from suicide within 2 years from the Issue Date of this Policy, We are liable only for the return of any Premiums received. For 2 years following the date of an addition, We shall be liable only for the return of Premiums paid, if any, which result from such addition.

MISSTATEMENT OF AGE OR SEX – If there is misstatement of age or sex of the Insured, the Death Benefit shall be that which would have been purchased by the most recent Premium at the correct age and sex. Amounts will be based on Our rates on the Issue Date. As used in this Policy, 'age' means age last birthday.

ASSIGNMENT – No Assignment will bind Us until recorded at Our Home Office. We are not obligated to determine that an Assignment is valid or sufficient. Any claim by an Assignee is subject to proof of the validity and extent of the Assignee's interest in the Policy. Unless otherwise specified by the Owner, Assignments shall take effect on the date the notice of Assignment is signed by Owner, subject to any payments made or actions taken by Us.

POWER TO MODIFY – Only Our President or Secretary has the power to:

- (a) change this Policy;
- (b) extend the time for payment of Premiums; or
- (c) waive any Policy provisions.

Any change in the Policy will be by an endorsement signed by one of the above-named officers.

NOTICES – All Notices, Applications, and other correspondence (including requests for a Policy change) required to be sent to Us under the terms of the Policy, or any attached rider must be mailed or delivered to Our Home Office in Galveston, Texas.

BASIS OF COMPUTATIONS – Cash values and Nonforfeiture Benefits of this Policy are not less than the minimum required by law in the state where this Policy is delivered. We have filed with the insurance regulators there, a detailed statement of the method used to compute cash values. Calculations are based on the mortality tables and rates of interest shown on the Data Page.

PREMIUMS

PREMIUM PAYMENT – Premiums will be payable in advance of coverage being effective:

- (a) while the Insured is living;
- (b) starting on the Issue Date;
- (c) during the Premium Period shown on the Data Page; and
- (d) at the Premium Mode and amount shown on the Data Page.

Premiums are payable to the Home Office, or the Company's authorized agent in exchange for an official receipt. The receipt will be signed by the President or Secretary and will be countersigned by the agent. The Premium Mode may be changed with Our consent upon written request.

GRACE PERIOD – A Grace Period of 31 days is granted for each Premium payment after the first. The Policy stays in force during this period. No interest is charged on the Premium Payment due during this time. If the Insured dies during the Grace Period, any Premium amount due will be deducted from the Death Benefit. Any payments sent via U.S. mail must be postmarked within the Grace Period.

LAPSE – If a Premium is not paid during the Grace Period, the Policy will Lapse, unless the Policy is continued as provided for in Nonforfeiture Benefits section.

LOANS

LOANS. Upon written request, We will make a Loan to You for all or part of the Cash Value of the Policy. At the time of the Loan request, all of these conditions must be met:

- (1) the Insured must be living;
- (2) the Policy must be in force;
- (3) the Policy must not then be subject to any Assignment; and
- (4) You must assign the Policy to Us, as sole security for the loan, on a form approved by Us.

Upon the Insured's death, the Death Benefit will be reduced by the amount of any Loan, including interest accrued to the date of death. We reserve the right to defer payment of any Loan for up to 6 months, except when such Loan is to pay a premium due to Us.

LOAN INTEREST RATE. We will charge interest daily at a fixed Loan Interest Rate of 8.0% annually.

LOAN INTEREST. Loan Interest is payable:

- (1) on each anniversary of the Policy's Issue Date; or
- (2) on the date the Loan is paid in full, if that date comes first.

Any interest not paid when it is due will be added to the amount of the outstanding Loan.

EXCESS POLICY DEBT. If the Policy Debt exceeds the cash value, this Policy will Lapse without further value. In no event will coverage provided by this Policy terminate until the end of the Grace Period. We will mail notice of Termination to You at your last known address and any Assignee of record 30 days prior to the actual Termination of the Policy.

LOAN REPAYMENT. All or part of a Loan on a Policy can be repaid at any time while this Policy is in force. However, if there is a Loan on the Policy on the last day of grace of a Premium in default, the Loan can be repaid only if the Policy is reinstated. Any payment not designated as a Loan repayment or Premium payment may be regarded as a Loan repayment.

NONFORFEITURE BENEFITS

NONFORFEITURE OPTIONS – If a Premium is not paid at the end of its Grace Period, You have certain benefits. You must tell Us in writing which one of these benefits You choose. This must be done within 60 days after the due date of the first Premium that is not paid. The cash value payable during the 60 day period shall be an amount not less than the cash value at the time of the due date of the first Premium that was not paid. The benefits are based on the Table of Nonforfeiture Values shown on the Data Page. Values shown are for a Policy free of Policy Debt with Premiums paid for completed years. In computing values for Policy Years not completed, allowance will be made for elapsed time and fractional year's Premiums paid. Values for times not shown will be furnished upon request. The options are:

PAID-UP INSURANCE - This Policy may be kept in force as reduced Paid-up Insurance. The Death Benefit will be the greatest amount that the cash value can purchase as a net single premium based on the Insured's attained age. The amount of cash value will be determined as of the due date of the first unpaid Premium, less any Policy Debt. The insurance will be payable at the same time and subject to the same conditions as the insurance under this Policy. This option will not include any supplementary benefits provided by rider under the original Policy.

CASH SURRENDER - This Policy may be surrendered for its cash value, if any, less any Policy Debt. The Owner may elect this option at anytime while the Policy is in force.

If no option has been elected, Paid-Up Insurance will be effective. You may ask Us in writing to pay the cash value of Paid-up at any time it is in force. You must return this Policy to Us. The cash value will be the value of future guaranteed benefits at the time of request, less any Policy Debt. The cash value payable on any request made within 30 days after a Policy anniversary date will not be less than the cash value on that anniversary. We may postpone payment of any cash value for up to 6 months.

TERMINATION AND REINSTATEMENT

TERMINATION – Coverage under this Policy will terminate on the first to occur of:

- (a) the Insured's death;
- (b) cessation of Premium Payments without a positive cash value;
- (c) expiration of the Grace Period; or
- (d) Our receipt of the Policy and Your written request for surrender of the full cash value.

REINSTATEMENT – You may reinstate this Policy after it has Lapsed. All of the following conditions must be met:

- (a) the Reinstatement must be within 5 years of the date of Termination;
- (b) You must give Us any facts We require to prove the Insured is insurable for the Policy at the same classification as on the Issue Date;
- (c) You must not have surrendered the Policy for its cash value;
- (d) all Premiums in arrears must be paid with compound interest. The interest rate will be 6% per year; and
- (e) any Policy Debt must be reinstated or paid back with interest. The interest rate for Reinstatement of Policy Debt will be 6% per year. If the Policy Debt with interest would exceed the cash value of the reinstated Policy, the excess must be paid before Reinstatement will be approved.

PROCEEDS TO BE PAID

PAYMENT OF DEATH BENEFIT – Any proceeds payable under the terms of this Policy are subject to any adjustments provided in the Misstatement of Age or Sex, Incontestability, and Suicide provisions of this Policy. The Death Benefit proceeds are payable to the Beneficiary upon receipt by Us of satisfactory Proof of Death of the Insured while this Policy is in force and are equal to:

- (1) 110% of the Premiums due and paid at the time of death if death occurs during the first two Policy Years; or
- (2) the Ultimate Face Amount if death occurs in the 3rd Policy Year or thereafter; plus:
 - (a) any Premium paid by You past the end of the Policy Month of the Insured's death; minus
 - (b) any unpaid Premium that may apply during a Grace Period; minus
 - (c) any Policy Debt.

If this Policy is in force as Paid-Up Insurance, the Death Benefit will be as described in the Nonforfeiture Benefits section.

If Death Benefit proceeds are not paid within thirty days from the date of Our receipt of due Proof of Death and determination of the right of the claimant to the proceeds, then such proceeds, including both the Death Benefit and any refund of Premiums at death will be paid with interest. Interest on the proceeds:

- (a) will accrue from the date of death to the date of payment;
- (b) will be calculated at an effective rate at least as great as required by law.

Proceeds may be paid in one sum or under the Settlement Options provision of this Policy.

ACCIDENTAL DEATH BENEFIT PROVISION

ACCIDENTAL DEATH BENEFIT – During the first two Policy Years, We will pay the Ultimate Face Amount as the Death Benefit upon receipt of due proof that the death of the Insured occurred as a direct result of accidental bodily injury, unless death was the result of the following Exclusions:

EXCLUSIONS:

- (1) suicide, or any attempt thereat, while sane or insane;
- (2) the commission of a felony;
- (3) war, declared or not;
- (4) participating in a riot;
- (5) travel or flight in or descent from any aircraft UNLESS the Insured is a fare-paying passenger on a scheduled airline;
- (6) illness or disease including medical or surgical treatments;
- (7) intentionally self-inflicted injury of any kind while sane or insane; or
- (8) voluntarily taking drugs, narcotics or hallucinogens, except those taken in accordance with a doctor's advice.

Otherwise, the amount of Death Benefit payable will be as described in the Payment of Death Benefit provision.

After the second Policy Year, the Exclusions regarding accidental bodily injury do not apply.

SETTLEMENT OPTIONS

AVAILABILITY OF SETTLEMENT OPTIONS – All or a part of the Death Benefit proceeds may be applied to any of the following options. We will first discharge in a single sum any liability under an Assignment of the Policy and any applicable Premium-related taxes, fees, or assessments imposed by any Federal, State, Municipal or other taxing authority. The remaining amount is the net sum payable. Other options can be used if agreed to by Us. If You have not elected a Settlement Option before the Insured's death, Option 2 with a certain period of 10 years will become effective. Any Settlement Option election must be written in a form that satisfies Us. Our consent is required for any of the following:

- (a) any payment to joint or successive Payees;
- (b) any payment to a corporation, association, partnership, trustee, or estate; or
- (c) any change in an option previously elected. We do not have to apply an option on a net sum payable of less than \$5,000 for any Payee.

SETTLEMENT OPTIONS – Periodic annuity payments may be made on an annual, semi-annual, quarterly, or monthly basis. You may select any basis such that the periodic payment is at least \$100. The Annuity Option tables illustrate minimum guaranteed monthly payments per \$1,000. The options are:

Option 1. Payments for a Fixed Period. Equal periodic payments will be paid for a fixed number of years. The amount of the payments will be based on Table A. Payments will include interest at the effective rate of 1.5% per year (additional interest may be paid at Our discretion).

Option 2. Life Annuity with 10 or 20 Years Certain. Equal periodic payments will be paid for as long as the Annuitant lives with payments certain for a fixed period of 10 years under Table B or 20 years under Table C.

Option 3. Life Annuity. Equal periodic payments under Table D will be paid for as long as the Annuitant lives with no payments certain; We have no liability upon the Annuitant's death.

Option 4. Payments of a Fixed Amount. Equal periodic payments will be paid. Payments will be paid until the total of the following amounts is exhausted: (1) the amount applied to this option, plus (2) interest at the effective rate of 1.5% per year (additional interest may be paid at Our discretion). The final payment will be the balance of the amount applied to this option plus interest. It may be more or less than the other payments.

Option 5. Interest Payments. We will hold the amount applied to this option at interest. Interest will be paid at the effective rate of 1.5% per year (additional interest may be paid at Our discretion). On interest due dates, You may make a withdrawal from the amount held. If such a withdrawal occurs, it must be for an amount of at least \$100. If the amount held falls below \$2,000, We may pay the entire amount held to You and will have no further liability.

With Our consent, any other Annuity Option acceptable to Us may be selected.

GENERAL PROVISIONS RELATING TO SETTLEMENT OPTIONS. You may surrender this Policy at or before the commencement of any distribution. The first payment under Option 1, 2, 3, or 4 is paid on the date the amount is applied to the option. The first payment under Option 5 is paid at the end of the first interest period. The first payment may be postponed for up to 10 years with Our consent. If so, the amount applied to the option will accumulate with compound interest at the effective rate of 1.5% per year. To avoid making payments of less than \$100 each, We can do either or both of the following:

1. change the payments to a quarterly, semi-annual, or annual basis; or
2. reduce the number of payments.

You can withhold the Beneficiary's right to assign, encumber, or commute any unpaid amount. Except to the extent permitted by law, unpaid amounts are not subject to any claims of a Beneficiary's creditor.

COMMUTATION OF SETTLEMENT OPTIONS: Commutation is the payment by Us of a lump sum in lieu of any future Annuity Payments. In no case may any life-contingent payments under Options 2 or 3 be commuted. At Our option, payments under the other options may be commuted. When an option is commuted, the effective interest rate used to compute the settlement option plus 1% will be used to calculate the present value of the future Annuity Payments.

If the Payee under Options 1, 2, 3, 4 or 5 dies after payments under the option have started, We will:

- (a) under Options 1 and 2, pay the commuted value of any unpaid fixed period payments to the Payee's estate; or
- (b) under Options 3, 4 or 5, pay any balance held by Us to the Payee's estate. With Our consent, the option elected may provide for payment in another manner.

BASIS OF CALCULATIONS. The payment amounts illustrated in the Settlement Option Tables are based on the Annuity 2000 Mortality Table (no projection scale used) and 1.5% interest. The attained age of the Payee when the settlement option is elected will be adjusted downward by one year for each full five year period that has elapsed since January 1, 2000. Benefits at the time of their commencement will not be less than those that would be provided by the application of the surrender value to purchase a single consideration immediate annuity contract at purchase rates offered by Us at the same time to the same class of annuitants.

SETTLEMENT OPTION TABLES

OPTION 1 – TABLE A

MONTHLY PAYMENTS FOR EACH \$1,000.00 OF THE NET SUM PAYABLE.

Multiply the monthly payment by 2.993 to obtain the quarterly payment, by 5.969 to obtain the semi-annual payment, and by 11.868 to obtain the annual payment.

Years	Amount	Years	Amount	Years	Amount	Years	Amount	Years	Amount
1	\$ 83.90	7	\$ 12.53	13	\$ 7.05	19	\$ 5.03	25	\$ 3.99
2	42.26	8	11.04	14	6.59	20	4.81	26	3.86
3	28.39	9	9.89	15	6.20	21	4.62	27	3.75
4	21.45	10	8.96	16	5.85	22	4.44	28	3.64
5	17.28	11	8.21	17	5.55	23	4.28	29	3.54
6	14.51	12	7.58	18	5.27	24	4.13	30	3.44

OPTION 2 OR 3 – TABLES B, C, AND D

MONTHLY PAYMENTS FOR LIFE FOR EACH \$1,000.00 OF THE NET SUM PAYABLE.

Age in years means age of Payee on birthday prior to the due date of the first payment. For Tables B and C, multiply the monthly payment by 2.993 to obtain the quarterly payment, by 5.969 to obtain the semi-annual payment, and by 11.868 to obtain the annual payment.

AGE IN YEARS	TABLE B Guaranteed Period 10 Years	TABLE C Guaranteed Period 20 Years	TABLE D Life Only	AGE IN YEARS	TABLE B Guaranteed Period 10 Years	TABLE C Guaranteed Period 20 Years	TABLE D Life Only
Male	Amount	Amount	Amount	Female	Amount	Amount	Amount
46	\$ 2.98	\$ 2.93	\$ 2.99	46	\$ 2.78	\$ 2.76	\$ 2.79
47	3.04	2.98	3.05	47	2.83	2.80	2.84
48	3.10	3.03	3.11	48	2.88	2.85	2.89
49	3.16	3.09	3.18	49	2.94	2.90	2.94
50	3.22	3.14	3.25	50	2.99	2.95	3.00
51	3.29	3.20	3.32	51	3.05	3.00	3.06
52	3.36	3.26	3.39	52	3.11	3.06	3.13
53	3.44	3.32	3.47	53	3.18	3.12	3.19
54	3.51	3.39	3.55	54	3.25	3.18	3.26
55	3.60	3.45	3.64	55	3.32	3.24	3.37
56	3.68	3.52	3.73	56	3.39	3.30	3.42
57	3.77	3.58	3.82	57	3.47	3.37	3.50
58	3.87	3.65	3.93	58	3.56	3.44	3.59
59	3.97	3.72	4.03	59	3.64	3.51	3.68
60	4.08	3.79	4.15	60	3.74	3.58	3.78
61	4.19	3.86	4.27	61	3.84	3.66	3.88
62	4.30	3.93	4.40	62	3.94	3.73	3.99
63	4.43	4.00	4.54	63	4.05	3.81	4.11
64	4.56	4.07	4.69	64	4.16	3.88	4.23
65	4.69	4.14	4.85	65	4.29	3.96	4.37
66	4.86	4.21	5.02	66	4.41	4.04	4.51
67	4.98	4.27	5.20	67	4.55	4.11	4.66
68	5.13	4.33	5.40	68	4.69	4.19	4.83
69	5.29	4.39	5.60	69	4.84	4.26	5.00
70	5.54	4.44	5.82	70	5.00	4.33	5.19
71	5.62	4.49	6.06	71	5.17	4.39	5.40
72	5.79	4.54	6.30	72	5.34	4.45	5.62
73	5.97	4.58	6.57	73	5.53	4.51	5.86
74	6.15	4.62	6.85	74	5.72	4.55	6.11
75	6.33	4.65	7.16	75	5.91	4.60	6.39
76	6.51	4.68	7.48	76	6.11	4.64	6.69
77	6.69	4.71	7.83	77	6.32	4.67	7.02
78	6.87	4.73	8.20	78	6.52	4.70	7.37
79	7.08	4.75	8.60	79	6.73	4.73	7.75
80**	7.23	4.76	9.02	80**	6.94	4.75	8.17

** and over



**AMERICAN NATIONAL INSURANCE COMPANY
A STOCK LIFE INSURANCE COMPANY**

HOME OFFICE: [ONE MOODY PLAZA, GALVESTON TX 77550]
ADMINISTRATIVE OFFICE: [ONE MOODY PLAZA, GALVESTON TX 77550]
TELEPHONE NUMBER [(409) 763-4661]

INDIVIDUAL WHOLE LIFE INSURANCE POLICY

- Premium Paying Period as shown on the Data Page
 - Nonparticipating. Dividends are not payable.
 - Reduced Death Benefit for the First Two Policy Years
 - Death Benefit payable in lump sum or as described in the Settlement Options provision.
 - This Policy is a Modified Endowment Contract
-

DATA PAGE

POLICY NUMBER	[12345678]	[MAY 1, 2010]	ISSUE DATE
OWNER	[JOHN DOE]		

INSURED

INSURED NAME	[JOHN DOE]	[65]	ISSUE AGE
CLASS	STANDARD	[MALE]	SEX

DEATH BENEFIT

The Death Benefit payable will be one of the following, depending on the Policy Year in which the Insured dies and the cause of death.

POLICY YEAR	ILLNESS OR OTHER NATURAL CAUSES	ACCIDENTAL BODILY INJURY
1 AND 2	110% Premiums Due and Paid	[\$8,000]
3 AND THEREAFTER	[\$8,000]	[\$8,000]

PREMIUMS

BENEFIT DESCRIPTION	INITIAL ANNUAL PREMIUM	PREMIUM PAYING PERIOD (YEARS)
GRADED BENEFIT WHOLE LIFE TO AGE 121	[\$ 844.16]	[57]
Form		Form GBL10
Maturity Date		[January 1, 2096]
TOTAL INITIAL ANNUAL PREMIUM	[\$ 844.16]	

MODAL PREMIUMS

INCLUDES PREMIUMS FOR Form GLB10 AND AN ANNUAL POLICY FEE OF \$[48.00]
YOUR CURRENT PREMIUM MODE IS: [ANNUAL]

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
[\$ 844.16]	[\$ 422.08]	[\$ 211.04]	[\$ 72.34]

MORTALITY TABLES

NONFORFEITURE VALUES ARE CALCULATED USING THE 2001 CSO ALB ULTIMATE MORTALITY TABLE FOR INSURED'S GENDER. ALL CALCULATIONS ASSUME THAT ALL PREMIUMS ARE RECEIVED AT THE BEGINNING OF THE POLICY YEAR AND THAT ALL DEATH CLAIMS ARE PAID AT THE END OF THE POLICY YEAR. AGE IS BASED ON AGE LAST BIRTHDAY.

DATA PAGE CONTINUED

POLICY NUMBER

[12345678]

INSURED

[JOHN DOE]

[MALE]

[65]

TABLE OF NONFORFEITURE VALUES

END OF POLICY YEAR	CASH OR LOAN VALUE	PAID UP INSURANCE
1	\$ [0.00]	\$ [0.00]
2	\$ [310.40]	\$ [602.43]
3	\$ [554.80]	\$ [1045.51]
4	\$ [803.04]	\$ [1469.96]
5	\$ [1055.20]	\$ [1876.93]
6	\$ [1310.24]	\$ [2265.77]
7	\$ [1566.08]	\$ [2634.71]
8	\$ [1821.04]	\$ [2982.99]
9	\$ [2075.76]	\$ [3313.08]
10	\$ [2330.48]	\$ [3626.71]
11	\$ [2584.80]	\$ [3924.55]
12	\$ [2838.08]	\$ [4207.11]
13	\$ [3088.48]	\$ [4473.65]
14	\$ [3333.84]	\$ [4723.21]
15	\$ [3573.28]	\$ [4956.46]
16	\$ [3805.44]	\$ [5173.44]
17	\$ [4030.24]	\$ [5375.51]
18	\$ [4248.40]	\$ [5564.40]
19	\$ [4459.76]	\$ [5741.05]
20	\$ [4662.96]	\$ [5905.25]
21	\$ [4856.48]	\$ [6056.75]
22	\$ [5039.04]	\$ [6195.51]
23	\$ [5209.84]	\$ [6321.83]
24	\$ [5368.40]	\$ [6436.17]
25	\$ [5514.48]	\$ [6539.07]
26	\$ [5650.48]	\$ [6632.92]
27	\$ [5779.04]	\$ [6719.90]
28	\$ [5900.40]	\$ [6800.54]
29	\$ [6014.00]	\$ [6874.71]
30	\$ [6119.12]	\$ [6942.27]
31	\$ [6217.44]	\$ [7004.59]
32	\$ [6311.60]	\$ [7063.44]
33	\$ [6400.96]	\$ [7118.57]
34	\$ [6484.16]	\$ [7169.26]
35	\$ [6558.80]	\$ [7214.24]
36	\$ [6626.64]	\$ [7254.74]
37	\$ [6693.28]	\$ [7294.18]
38	\$ [6758.48]	\$ [7332.35]
39	\$ [6822.40]	\$ [7369.51]
40	\$ [6884.80]	\$ [7405.45]
41	\$ [6945.68]	\$ [7440.22]
42	\$ [7004.96]	\$ [7473.80]
43	\$ [7062.64]	\$ [7506.22]
44	\$ [7118.64]	\$ [7537.45]



APPLICATION FOR INDIVIDUAL GRADED BENEFIT WHOLE LIFE INSURANCE POLICY

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

ABOUT YOU

Name: E-mail: Address: Apt. City: State: ZIP Code: Home Phone: Work Phone: Social Security Number: Date of Birth: Female Male Optional Secondary Addressee (for notification of past due premiums): Name: Address: City: State: ZIP Code:

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: [Graded Benefit Whole Life] Amount: [\$10,000] [\$5,000] [\$3,000] Other: \$ Beneficiary: Relationship: If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate. Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? 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 voided check.)] [2. Charge monthly premiums to my: Visa MasterCard Discover Visa, MasterCard or Discover Account Number Exp. Date] [3. Bill me. (Send no money now.)]

AGREEMENTS AND REPRESENTATIONS

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.

I represent the information above is true and complete to the best of my knowledge and belief. I understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. I also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during my lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information. [I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.]

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. (AK): A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. (AR): Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (DE): Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. (ID): Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. (IN): A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature of Applicant: X Date: X Month / Day / Year

SERFF Tracking Number: AMNA-126645344 State: Arkansas
 Filing Company: American National Insurance Company State Tracking Number: 46076
 Company Tracking Number:
 TOI: L071 Individual Life - Whole Sub-TOI: L071.201 Early Duration Reduced Benefit - Level Premium - Any Policy Design
 Product Name: AD - GBL
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR - Certification of Compliance.pdf		

	Item Status:	Status Date:
Satisfied - Item: Screen Prints - Online and Telephone Process		
Comments:		
Attachments: 10301-01 - Online Screens (Pages 1-10).pdf 10301-01 - Online Screens (Pages 11-20).pdf 10301-01 - Online Screens (Pages 21-28).pdf 10301-01 - Telephone Screens (Pages 1-15).pdf 10301-01 - Telephone Screens (Pages 11-28).pdf 10301-01 - Recorded Disclosure Scripts.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachments: MEMORANDUM OF VARIABLE MATERIAL - 10301-01.pdf MEMORANDUM OF VARIABLE MATERIAL - Form GBL10(10).pdf MEMORANDUM OF VARIABLE MATERIAL - Form GBL10DM-DP.pdf		



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
Rule & Regulation 49
ACA 23-79-138 and Bulletin 15-2009
ACA 23-80-206 (Flesch Certification, minimum of 40)

<u>Form</u>	<u>Form Name</u>	<u>Scoring(s)</u>
Form GBL10(10)	Individual Whole Life Insurance Policy	56.7
Form GBL10DM-DP	Specifications Page used with Form GBL10(10)	52.7
10301-01	Application for Individual Graded Benefit Whole Life Insurance Policy	
	<i>as scored with the policy form</i>	51.8

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

HELPING YOU GET THE MOST OUT OF LIFE



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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: * -

Gender: * Male Female

Date of Birth: * / /

E-Mail Address: *

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

Coverage Amount * (in whole dollars)

[Get Quote!](#)

Underwritten by



10301-I

1-800-635-8565





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

HELPING YOU GET THE MOST OUT OF LIFE



**ANICO
DIRECT**
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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"/> ANICO Legacy Life - Graded Benefit Whole Life	\$10,000.00	\$71.30	\$932.50	\$2234.70	\$4965.40

To find out more about these products and how they can meet your needs, simply click on the product name above.

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

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Applicant Information page

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[Contact Us](#)

Applicant Information (Continued)

All asterisked * fields must be completed.

Social Security Number: * - -

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

Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? * Yes No

[Refuse](#)

[Continue](#)

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10301-I

1-800-635-8565



If Replacement of Insurance is selected this page will display.

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Policy Replacement Advisory

We cannot make this offer if the product is intended to replace your existing coverage.

Close

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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:	<input type="text"/>	Middle Initial:	<input type="checkbox"/>	Last Name:	<input type="text"/>
Suffix:	<input type="text"/>				
Relationship:	<input type="text"/>				
Additional Beneficiary Information:	<input type="text"/>				

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

Secondary Addressee

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Applicant Information (Continued)

All asterisked * fields must be completed.
You may name an optional Secondary Addressee to receive notification of past due premiums on your policy.

Secondary Addressee:

First Name: Middle Initial: Last Name:

Suffix:

Mailing Address:

City: State:

Zip: -

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Representations

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HAVE A QUESTION?
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Representations

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.

You agree and represent that this information is true:

Yes No

Back

Continue

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If No to Representations

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[FAQ](#)

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[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

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American National
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10301-I

1-800-635-8565



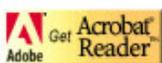
Review App/Proposed Insured page

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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.

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 Life 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

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Change of address information

Salutation: *

First Name: * Middle Initial: Last Name: *

Suffix:

Primary Mailing Address:

City: * State: TX Zip: * -

Daytime Telephone Number: * - - Evening Telephone Number: - -

Back Continue

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Salutation: Dr., Mr., Mrs., Ms
Suffix: I, II, III, IV, V, Jr., Sr.

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[About Us](#)

[FAQ](#)

[Privacy](#)

[Contact Us](#)

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.

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

Back

Continue

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

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Without the required electronic signatures, we cannot continue online processing of your application. To change your selection, just click the "Back" button below and click the Accept button on that screen. If, however, you choose not to utilize this convenient timesaving feature, you may still apply for coverage by selecting either option 1 or 2 below:

- Option 1** - Please process my completed but unsigned application. I understand that, if approved, I will receive my policy in the mail and that it will contain a copy of the application I just completed. I will need to sign and return a copy of the application together with my initial premium before any insurance will go into effect.

- Option 2** - I would prefer to print my application, sign it, and send it to American National Insurance Company at P.O. BOX 696700 San Antonio, TX 78269. I understand that, if approved, I will receive my policy in the mail and that I must remit my initial premium before any insurance will go into effect.

- Option 3** - Please discontinue processing my application. I understand that I may return at a future date and apply again but I will have to complete a new application at that time.

Back

Continue

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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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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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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 Life Insurance Company at the following address:

American National Life 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 your policy will be mailed. The next screen will present the application as you've completed it to this point. Please do not 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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Thank You!

Thank you for considering American National Life 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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10301-I



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HAVE A QUESTION?
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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 (\$71.30 monthly)   

PayPal (\$71.30 monthly) 

Automatic Deductions from Your Checking or Savings Account (\$71.30 monthly)

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

Back

Continue

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10301-I

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

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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: **Graded Benefit Whole Life**
Monthly Premium: **\$71.30**

Card Type: *   

Cardholder's Name: *

Card Number: * Security Code:

Expiration Date: * /

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

Street: * City: *

State: * Zip: * -

Back Continue

Underwritten by:

10301-I

1-800-635-8565
   



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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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: **Graded Benefit Whole Life**
Monthly Premium: **\$71.30**

Account Holder's Name:

Account Holder's Address:

Account Holder's City, State Zip: , -

DATE: [Apr 01, 2010](#)

PAY TO THE ORDER OF American National Insurance Company \$

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

Back Continue

Underwritten by

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1-800-635-8565




State: All 50 states including D.C.

Type: Checking, Savings

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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](#)

Underwritten by:

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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).**



**APPLICATION FOR
INDIVIDUAL GRADED BENEFIT
WHOLE LIFE INSURANCE POLICY**

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

ABOUT YOU

Name: Mr GBL TESTS III E-mail: EMAIL@TEST.COM
 Address: 567 MAIN ST Apt. _____
 City: SAMPLE CITY State: SAMPLE STATE ZIP Code: 12345
 Home Phone: (281) 333 - 3333 Work Phone: (281) 222 - 2222
 Social Security Number: 555 - 55 - 5555 Date of Birth: 01 / 01 / 1951 Female Male
 Optional Secondary Addressee (for notification of past due premiums): Name: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Graded Benefit Whole Life Amount: \$ 10,000
 Beneficiary: BEN TWO II Relationship: SON
If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.
 Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? 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 VISA CARD

AGREEMENTS AND REPRESENTATIONS

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.
I represent the information above is true and complete to the best of my knowledge and belief. I understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. I also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during my lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information.
FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **(AK):** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **(AR):** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **(DE):** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **(ID):** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **(IN):** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature of Applicant: X _____ Date: X 04 / 13 / 2010
10301-01 Month Day Year

CLICK TO SIGN HERE



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

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

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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).**

**APPLICATION FOR
INDIVIDUAL GRADED BENEFIT
WHOLE LIFE INSURANCE POLICY**
American National Insurance Company
P.O. BOX 696700
San Antonio, TX 78269

ABOUT YOU

Name: Mr.GBL TESTS III E-mail: EMAIL@TEST.COM
 Address: 567 MAIN ST Apt. _____
 City: SAMPLE CITY State: SAMPLE STATE ZIP Code: 12345
 Home Phone: (281) 333 - 3333 Work Phone: (281) 222 - 2222
 Social Security Number: 555 - 55 - 5555 Date of Birth: 01 / 01 / 1951 Female Male
 Optional Secondary Addressee (for notification of past due premiums): Name: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Graded Benefit Whole Life Amount: \$ 10,000
 Beneficiary: BEN TWO II Relationship: SON
If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.
 Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? 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 VISA CARD

AGREEMENTS AND REPRESENTATIONS

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.

I represent the information above is true and complete to the best of my knowledge and belief. I understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. I also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during my lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. (AK): A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. (AR): Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (DE): Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. (ID): Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. (IN): A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature of Applicant: X Date: X 04 / 13 / 2010
10301-01 Month Day Year



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

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

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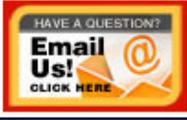
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Electronic Review and Signing Process page, showing all documents are signed

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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	Signed ✓

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

[Continue](#)

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If the payment method is direct bill this page will display.

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HAVE A QUESTION?
Email Us!
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Thank You For Applying Online!

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.

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.

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

Close

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1-800-635-8565
   



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

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**ANICO
DIRECT**
A Division of American National Insurance Company





HAVE A QUESTION?
Email Us!
CLICK HERE

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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](#)

Underwritten by:

**AMERICAN
NATIONAL**
American National
Insurance Company
10301-I

1-800-635-8565





Final application sent to Cyberlife.



APPLICATION FOR INDIVIDUAL GRADED BENEFIT WHOLE LIFE INSURANCE POLICY

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

ABOUT YOU

Name: Mr. GBL TESTS III E-mail: EMAIL@TEST.COM
Address: 567 MAIN ST Apt. _____
City: SAMPLE CITY State: SAMPLE STATE ZIP Code: 12345
Home Phone: (281) 333 - 3333 Work Phone: (281) 222 - 2222
Social Security Number: 555 - 55 - 5555 Date of Birth: 01 / 01 / 1951 Female Male
Optional Secondary Addressee (for notification of past due premiums): Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Graded Benefit Whole Life Amount: \$ 10,000
Beneficiary: BEN TWO II Relationship: SON
If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.
Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? 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.

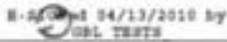
Charge my monthly premiums to my VISA CARD

AGREEMENTS AND REPRESENTATIONS

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.

I represent the information above is true and complete to the best of my knowledge and belief. I understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. I also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during my lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **(AK):** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **(AR):** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **(DE):** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **(ID):** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **(IN):** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature of Applicant: X  Date: X 04 / 13 / 2010
Month Day Year

10301-01

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Get A FastQuote

All asterisked * fields must be completed.

Promotion Name: *

State of Residence: *

Date of Birth: * / /

Gender: * Male Female

Coverage Amount *
(in whole dollars)

First Name: Middle Initial: Last Name:

Suffix:

Primary Mailing Address:

City:

Zip: -

E-Mail Address:

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

[Get Quote!](#)

Underwritten by:



American National
Insurance Company
10301-C

1-800-638-8565





Promotion Name: Company marketing promotions

State: All 50 states including D.C.

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

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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"/> ANICO Legacy Life - Graded Benefit Whole Life	\$10,000.00	\$71.30	\$932.50	\$2234.70	\$4965.40

To find out more about these products and how they can meet your needs, simply click on the product name above.

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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Insurance Company
10301-C

1-800-635-8565



Get a Fast Quote page (cont)

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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: * - -

Refuse Continue

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10301-C

1-800-635-8565





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

State: All 50 states including D.C.

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[Contact Us](#)

Applicant Information (Continued)

All asterisked * fields must be completed.

Social Security Number: * - -

Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? * Yes No

[Refuse](#)

[Continue](#)

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10301-C

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If "Replacement" questions is answered Yes, the following is displayed.

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Policy Replacement Advisory

We cannot make this offer if the product is intended to replace your existing coverage.

[Close](#)

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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:	<input type="text"/>	Middle Initial:	<input type="checkbox"/>	Last Name:	<input type="text"/>
Suffix:	<input type="text"/>				
Relationship:	<input type="text"/>				
Additional Beneficiary Information:	<input type="text"/>				

RefuseBackContinue

Underwritten by

10301-C

1-800-635-8565
   



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

Secondary Addressee

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Applicant Information (Continued)

All asterisked * fields must be completed.
You may name an optional Secondary Addressee to receive notification of past due premiums on your policy.

Secondary Addressee:

First Name: Middle Initial: Last Name:

Suffix:

Mailing Address:

City: State:

Zip: -

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10301-C

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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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American National Insurance Company
10301-C

1-800-635-8565



Please see “IC Portal Recorded Disclosure Scripts.pdf” for details on recording.

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

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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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10301-C

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

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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 (\$71.30 monthly)   
- Automatic Deductions from Your Checking or Savings Account (\$71.30 monthly)
- Direct Billing on a monthly, quarterly, semi-annual or annual basis

[Refuse](#)

[Back](#)

[Continue](#)

Underwritten by

American National
Insurance Company
10301-C

1-800-635-8565



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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: **Graded Benefit Whole Life**
Monthly Premium: **\$71.30**

Card Type: *   

Cardholder's Name: *

Card Number: * Security Code:

Expiration Date: * /

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

Street: * City: *

State: * Zip: * -

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

Underwritten by

American National Insurance Company
10301-C

1-800-635-8565

Card Type: MasterCard, Visa, Discover

Month: January - December

Year: 2010 - 2015

State: All 50 states including D.C.

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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: **Graded Benefit Whole Life**
Monthly Premium: **\$71.30**

Account Holder's Name:

Account Holder's Address:

Account Holder's City, State Zip: , -

DATE: [Apr 05, 2010](#)

PAY TO THE ORDER OF American National Insurance Company \$

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

Refuse Back Continue

Underwritten by



10301-C

1-800-635-8565





State: All 50 states including D.C.
Type: Checking, Savings

Representations

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Representations

Please play the recording for the customer.



You agree and represent that this information is true:

Yes No

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

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American National
Insurance Company
10301-C

1-800-635-8565
   



If No to representations

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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](#)

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10301-C

1-800-635-8565



Agreements

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Consent to Agreements

Please play the recording about Agreements and Representations.



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

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American National
Insurance Company
10301-C

1-800-635-8565



Consent to Agreements is considered accepted when the application is signed via electronic signature.

Please see “IC Portal Recorded Disclosure Scripts.pdf” for details on recording.

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Electronic Review And Signing Process

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

[Continue](#)

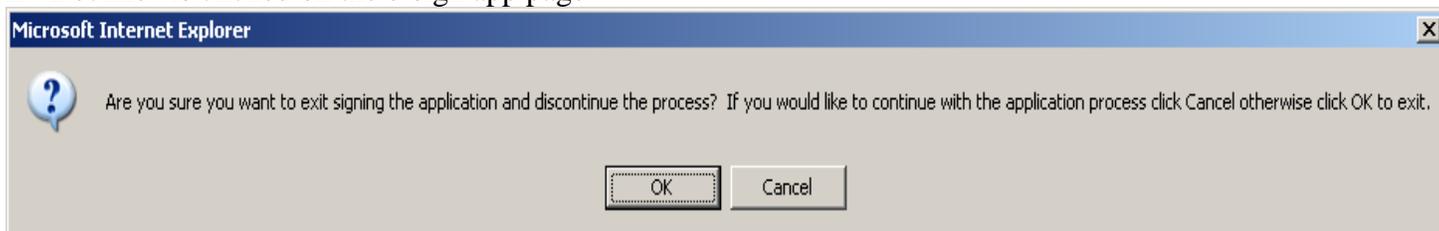
Underwritten by

American National
Insurance Company
10301-C

1-800-635-8565



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





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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).**



**APPLICATION FOR
INDIVIDUAL GRADED BENEFIT
WHOLE LIFE INSURANCE POLICY**

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

ABOUT YOU

Name: Mr. GBL TESTS III E-mail: EMAIL@TEST.COM

Address: 567 MAIN ST Apt. _____

City: SAMPLE CITY State: SAMPLE STATE ZIP Code: 12345

Home Phone: (281) 333 - 3333 Work Phone: (281) 222 - 2222

Social Security Number: 555 - 55 - 5555 Date of Birth: 01 / 01 / 1951 Female Male

Optional Secondary Addressee (for notification of past due premiums): Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Graded Benefit Whole Life Amount: \$ 10,000

Beneficiary: BEN TWO II Relationship: SON

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

Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? 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 VISA CARD

AGREEMENTS AND REPRESENTATIONS

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.

I represent the information above is true and complete to the best of my knowledge and belief. I understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. I also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during my lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **(AK):** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **(AR):** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **(DE):** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **(ID):** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **(IN):** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature of Applicant: X _____ Date: X 04 / 13 / 2010
10301-01 Month Day Year



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

Decline
Back
Continue



This page shows that the app was signed.

HELPING YOU GET THE MOST OUT OF LIFE



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Electronic Review And Signing Process

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

[Continue](#)

Underwritten by

American National Insurance Company
10301-C

1-800-635-8565



If the payment method is direct bill this page will display.

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[FAQ](#)

[Privacy](#)

[Contact Us](#)

Thank You For Applying Online!

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.

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.

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

Close

Underwritten by:

American National
Insurance Company
10301-C

1-800-635-8565



If payment has been received this page will display

HELPING YOU GET THE MOST OUT OF LIFE



[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

Underwritten by

American National
Insurance Company
10301-C

1-800-635-8565



Final application sent to Cyberlife.



APPLICATION FOR INDIVIDUAL GRADED BENEFIT WHOLE LIFE INSURANCE POLICY

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

ABOUT YOU

Name: Mr. GBL TESTS III E-mail: EMAIL@TEST.COM
Address: 567 MAIN ST Apt. _____
City: SAMPLE CITY State: SAMPLE STATE ZIP Code: 12345
Home Phone: (281) 333 - 3333 Work Phone: (281) 222 - 2222
Social Security Number: 555 - 55 - 5555 Date of Birth: 01 / 01 / 1951 Female Male
Optional Secondary Addressee (for notification of past due premiums): Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____

YOUR BENEFICIARY AND AMOUNT OF COVERAGE

Plan: Graded Benefit Whole Life Amount: \$ 10,000
Beneficiary: BEN TWO II Relationship: SON
If no beneficiary survives the owner, or none is named, payment will be made to the owner's estate.
Do you intend to replace, discontinue, or change any existing life insurance policy issued by any company in relation to your purchase of this product? 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.

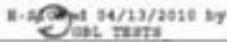
Charge my monthly premiums to my VISA CARD

AGREEMENTS AND REPRESENTATIONS

I have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). I am not awaiting an organ or bone marrow transplant. I have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and I am not confined in such a facility. I am not currently hospitalized and do not use an oxygen tank. I do not require the assistance of another person for dressing, bathing, or mobility. I understand that the company will offer no more than \$25,000 of life insurance under this product.

I represent the information above is true and complete to the best of my knowledge and belief. I understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. I also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during my lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **(AK):** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **(AR):** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **(DE):** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **(ID):** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **(IN):** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature of Applicant: X  Date: X 04 / 13 / 2010
Month Day Year

10301-01

All States –

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".

01 Application (AR)

01 - Representation

You acknowledge that you have never been diagnosed by a member of the medical profession as having Alzheimer's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV). You are not awaiting an organ or bone marrow transplant. You have not been advised by a licensed medical professional to be admitted to a nursing home or hospice and you are not confined in such a facility. You are not currently hospitalized and do not use an oxygen tank. You do not require the assistance of another person for dressing, bathing, or mobility. You understand that the company will offer no more than \$25,000 of life insurance under this product. Do you agree and represent that this information is true?

01 - Agreements (AR)

You represent the information is true and complete to the best of your knowledge and belief. You understand that a reduced death benefit amount equal to 110% of premiums due and paid is payable during the first two years if death occurs from sickness or natural causes. You also understand that no insurance shall take effect until a policy is issued and the first premium is received by American National Insurance Company during your lifetime. To verify your identity and comply with the USA Patriot Act, we may use third party information. We may disclose your personal information without notice only as permitted by law. You may access and correct your records and request a detailed description of how we gather and manage personal information.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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"



MEMORANDUM OF VARIABLE MATERIAL for 10310-01

This memorandum was prepared for use with 10310-01, the Application for Individual Graded Benefit Whole Life Insurance. 10310-01 is an individual life insurance application used for the graded benefit product 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:

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. The current range of simplified issue products is:

Graded Benefit Whole Life

We certify that only approved products will be marketed via this application. An updated memorandum of variable material will be filed with an updated range with the addition of any new products for which this application can be used.

AMOUNT: Based on the Plan shown, the three most popular applied for face amounts (based on experience and/or market research) will be pre-filled as possible selections. A reasonable range for the displayed amounts, considering the above plan would be: (Min.) \$3,000 (Max) \$25,000.

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.

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."

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.)



MEMORANDUM OF VARIABLE MATERIAL for 10301 (continued)

CONSUMER DISCLOSURE STATEMENT – Within the Agreements section, the 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.



**MEMORANDUM OF VARIABLE MATERIAL FOR
Form GLB10(10)
June 4, 2010**

This memorandum was prepared for use with Form GLB10(10), an individual whole life policy for American National Insurance Company.

Variable material contained within the form denoted by use of brackets.

Variable Material

The form contains the following permissible variable material:

Home Office Address
Administrative Office Address
Business (telephone number)
Officer Names, Titles, and Signatures

The above noted items, if changed, will be changed in accordance with department standards. It is understood that the items noted above may be changed without notice or prior approval.

The form also contains the following variable fields, considered illustrative:

Insured
Ultimate Face Amount
Policy Number
Issue Date

The information printed in the above fields will vary on an individual basis. The information within the field will be established on the date of issue and will not change during the lifetime of the policy.

The form also contains the following variable field:

Right to Examine. As this policy form will be used for both agent solicited and direct marketing, the Right to Examine provision, located on page 1, will vary accordingly. When the policy is issued direct marketing, the following text will be displayed:

You may cancel this Policy for any reason within 30 days after its receipt. You must mail or deliver the Policy to Our Home Office. Any premiums paid, including any Policy Fee or other charges, will be refunded to You. The Policy will then be treated as if it were never issued.

When the policy is issued agent solicited, the following text will be displayed:

You may cancel this Policy for any reason within 20 days after this Policy is delivered. You may cancel it by returning the Policy, with a written request to cancel, to Our Home Office or the agent who took the Application. Any premiums paid, including any Policy Fee or other charges, will be refunded to You. The Policy will then be treated as if it were never issued.

Additionally, we would like to reserve the right to update the Right to Examine provision in accordance with any future regulations. Any update in relation to such regulation would be filed in accordance with your department's requirements.

We certify to the following:

- The final form issued to the consumer will not contain brackets denoting variable text;
- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation as required.



**MEMORANDUM OF VARIABLE MATERIAL FOR
Form GBL10DM-DP
June 4, 2010**

This memorandum was prepared for use with Form GBL10DM-DP, a specifications page used in conjunction with an individual whole life policy (Form GBL10) for American National Insurance Company's direct solicitation marketing branch.

Variable material contained within the form denoted by use of brackets.

Variable Material

The form contains the following variable fields, considered illustrative:

Policy Number – will be a unique identifying number systematically assigned by the company.

Issue Date – will be the date the policy was issued by the company.

Owner – will be the Owner's name as provided in the application.

Insured Name – will be the Insured's name as provided in the application.

Issue Age – will be the Insured's age. The applicable range for this product is a minimum of 50 and maximum of 80.

Sex – the policy is issued on a sex distinct basis. The applicable values for this field will be male or female.

Death Benefit – the amount of the death benefit will be a minimum of \$3,000 and a maximum of \$25,000.

Form – this field will display the form number of the approved policy form for your state. The XX represents a two-digit state code, used when a particular state uses a policy form specific to their state. If no 'special state' version is required, only Form GBL10 will display. The form number is also displayed in the Modal Premiums section.

Maturity Date – the policy's maturity date is the policy anniversary following the Insured's 121st birthday.

Initial Annual Premium – will be the Initial Annual Premium for the policy issued. This amount is based on the Insured's information and the face amount of the policy, and includes the amount of the annual policy fee.

Premium Paying Period (Years) – the total number of years premiums are payable. This number will be equal to the number of years until the policy year following the Insured's 121st birthday.

Total Initial Annual Premium – is the total amount of initial premium which is a sum of the base policy plus any riders and/or supplemental benefits. At this time no riders or supplemental benefits are offered with this product.

Policy Fee amount – the policy fee for this product is currently \$48.00. While we do not foresee changing the amount of the fee with any frequency, it is filed as variable to allow for changes at the policy level. A reasonable range for the policy fee would be \$0 (no policy fee) to \$100.00.

Modal Premium Amounts – will display the amount of premiums based on the available premium modes. Amounts shown will include the applicable policy fee.

Table of Nonforfeiture Values – the table provides the Cash or Loan Value and Paid Up Insurance amount for each policy year, based on the Insured’s information, face amount, and expected annual premium.

We certify to the following:

- The final form issued to the consumer will not contain brackets denoting variable text;
- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation.