

SERFF Tracking Number: ANTX-127626794 State: Arkansas
Filing Company: American National Life Insurance Company of Texas State Tracking Number: 49794
Company Tracking Number:
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: REV MIG GAP APP
Project Name/Number: /

Filing at a Glance

Company: American National Life Insurance Company of Texas

Product Name: REV MIG GAP APP SERFF Tr Num: ANTX-127626794 State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved State Tr Num: 49794
Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: State Status: Under Review
Filing Type: Form Reviewer(s): Donna Lambert
Author: Deborah Biediger Disposition Date: 10/04/2011
Date Submitted: 09/15/2011 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date: 11/04/2011
State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: This application is state specific to Arkansas and so is not filed in any other state.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 10/04/2011
State Status Changed: 09/30/2011
Deemer Date: Created By: Deborah Biediger
Submitted By: Deborah Biediger Corresponding Filing Tracking Number:
Filing Description:
We wish to make some revisions to the application that was approved under SERFF filing number ANTX-127366701 effective 8/19/2011.
We have not yet begun marketing of this product so we request that we be allowed to retain the application's current form designation of ANL-GAPAPP6(AR).
A redlined copy of this application which shows all the revisions made to this approved application is attached under the Supporting Documentation tab. No other revisions have been made.

Company and Contact

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Filing Contact Information

Deborah Biediger, Compliance Analyst deborah.biediger@anico.com
 One Moody Plaza SSH MP, Ste. 200 281-538-4838 [Phone]
 Galveston, TX 77550 409-766-2024 [FAX]

Filing Company Information

American National Life Insurance Company of Texas CoCode: 71773 State of Domicile: Texas
 One Moody Plaza, SSH MP, Ste.200 Group Code: 408 Company Type: Health Insurance
 Galveston, TX 77550 Group Name: State ID Number:
 (281) 538-4842 ext. [Phone] FEIN Number: 75-1016594

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: Retaliatory fee and Arkansas per form filing fee of \$50.00 are the same.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Life Insurance Company of Texas	\$50.00	09/15/2011	51619775

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/04/2011	10/04/2011

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Disposition

Disposition Date: 10/04/2011

Implementation Date: 11/04/2011

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application	Accepted for Informational Purposes	No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	REDLINED REVISED APPLICATION		No
Form	APPLICATION	Approved	No

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Form Schedule

Lead Form Number: ANL-GAPAPP6(AR)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/04/2011	ANL- GAPAPP6(AR)	Application/ Enrollment Form	APPLICATION	Revised	Replaced Form #: ANL-GAPAPP6(AR) Previous Filing #: ANTX-127366701		rev AR app.pdf

**Application to
American National Life Insurance Company of Texas • P.O. Box 696870 • San Antonio, Texas 78269**

Please Print - Use Black Ink New Policy Reinstatement Existing #: _____ Change Existing _____

1. Special Requests: Mail Policy to Applicant: Yes No Requested Effective Date: _____

2. Please print the full name of all Proposed Insureds (use additional sheet and attach if needed).

Last, First, Middle Initial	Occupation	Relationship	Sex M/F	Date of Birth	Age	Height	Weight	Social Security Number
1.		Applicant						
2.		Spouse						
3.								
4.								
5.								
6.								

3. Home Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Cellular: (____) _____ Email Address: _____

I am applying for:

4. Base Plan Daily Benefit Amount: \$ 100 \$ 250 \$ 500 AD&D Beneficiary: _____
Emergency Room Benefit: \$ 250 \$ 500 AD&D Beneficiary Relationship: _____
Initial Daily Benefit Period: 2 Days 5 Days 10 Days
Initial Daily Benefit Amount: \$ 250 \$ 500 \$ 1,000 \$ 1,500 \$ 2,000 \$ 2,500
Base Plan Annual Premium: _____

Optional Benefits:

Critical Illness Rider : \$5,000 \$10,000 _____
Critical Illness Beneficiary: _____ Relationship _____
Outpatient Diagnostic Imaging Rider: \$2,000 \$3,500 _____
Outpatient Surgical Rider: Option A Option B _____
Mode: Annual Quarterly Semi-Annual Monthly PAC List Bill Total Annual Premium: _____

Total Premium Collected with Application: _____

5. Does any Proposed Insured currently have more than one Medical Expense and/or Hospital Indemnity Policy with this or any other company)?..... Yes No
If Yes, please name company and give details in chart below:

Plan Type	Company	To Be Replaced?	Plan Type	Company	To Be Replaced?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY AND RELATED INFORMATION

This plan can not be issued to any person who answers "yes" to question 6, 7, 8, or 9. Do not apply for coverage for this person.

6. Is any Proposed Insured or family member of the household an expectant mother or expectant father?..... Yes No
7. Within the past 2 years, has any Proposed Insured had symptoms, treatment, or been recommended to have treatment for: Alcohol or Drug Abuse, Alzheimer's, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Ulcerative Colitis, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins Disease, End Stage Renal Disease, Leukemia, Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's Disease, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)?..... Yes No
8. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other Immune Disorder?..... Yes No
9. Has any Proposed Insured been advised to be admitted to a hospital, nursing home, clinic, or other institution for diagnosis or treatment, or had surgery or medical tests recommended, but not yet performed?..... Yes No

MEDICAL HISTORY AND RELATED INFORMATION *continued*

10. Has any Proposed Insured ever been declined, restricted, rated-up, or postponed for any kind of life or health insurance with this or any other company?..... Yes No
If Yes, give details: _____
11. Has the Applicant used any form of tobacco within the past 12 months?..... Yes No
Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months?..... Yes No
12. Has any Proposed Insured within the past 2 years, taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting aircraft (any type), or rodeo events?..... Yes No
If Yes, indicate activity and give details: _____
13. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's, or been arrested within the past 2 years?..... Yes No
If Yes, give details and provide Driver's License # and state of issue: _____
14. Has any Proposed Insured received medical counseling, been treated in an emergency room or urgent care center, been admitted to any hospital, nursing home, clinic, or other institution for diagnosis or treatment within the past 2 years? Yes No
15. Has any Proposed Insured taken a medication recommended or prescribed by a Physician in the past 12 months? Yes No
16. Has any Proposed Insured had symptoms of, or been treated for, any of the following within the past 2 years:
- Chest Pain Lung/Respiratory Intestines or Colon Mental or Nervous Disorder
- Joints/Knees/Spine Reproductive Organs Kidneys
- Hernia Gallbladder Liver
- Prostate Disorder Urinary Tract Pancreas

Give full details below of all "Yes" answers to questions 14-16, include all dates, names and addresses of hospitals and all Physicians, nature of the condition or impairment, the treatment or advice given, and if released from the treatment (use additional sheet and attach if needed).

Question Number	Proposed Insured	Date of Treatment Begin - End		Reason for Condition Diagnosis, Injury, etc.	Degree of Recovery	Name/Address of Attending Physicians Street, City, State

APPLICATION DECLARATION AND AGREEMENTS

ATTENTION — After this application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I have received *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

FRAUD WARNING — Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of a felony.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned represents that the answers and statements on this application are true, complete, and correctly recorded; and agree they will be used to determine each Proposed Insured's eligibility for coverage under the health insurance plan requested hereby. I understand and agree that: 1. all statements and answers in this application and in any supplements or amendments to it are complete and true; 2. any incorrect or incomplete information on this application may result in loss of coverage or claim denial; 3. no insurance shall take effect unless a policy is issued (or this application is made to change or reinstate an existing policy, unless the change is approved) and actually delivered to the Applicant and the first full premium paid during the lifetime and continued health of all Proposed Insureds as represented in this application. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the policy issued.

If this application is taken over the telephone or electronically, I agree that my electronic signature serves as my original signature.

I understand and agree that:

- eligibility for the Plan does not constitute initial coverage under the Plan; and
- initial coverage under the Plan is subject to the Company's criteria.

Signed at _____
City State Zip Code Date

Applicant's Signature Spouse's Signature
(if coverage is requested for spouse)

Agent Name: _____ ANTEX Writing Number: _____

Fax Number: _____ Email Address: _____

FAIR CREDIT REPORTING ACT (FCRA) PRE-NOTIFICATION

Federal and state law requires notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing proper identification, you may inspect or receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of you family, employers or business associates, financial sources, friends, neighbors or other with whom you are acquainted. The information will consist, when applicable, of a confirmation or your identity, age, residence, marital status and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.

MEDICAL INFORMATION BUREAU (MIB) PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. American National Life Insurance Company of Texas, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Life Insurance Company of Texas, or its reinsurers, may also release information in its file to other insurance companies to who you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment:			
	app readability.pdf		
Bypassed - Item:	Application	Accepted for Informational Purposes	10/04/2011
Bypass Reason:	The application is attached under the Forms tab.		
Comments:			
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	N/A - SUBMISSION OF THIS REVISED APPLICATION DOES NOT AFFECT RATES ON FILE FOR PRODUCT THIS APPLICATION IS UTILIZED WITH.		
Comments:			
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	N/A - SUBMISSION OF THIS REVISED APPLICATION DOES NOT AFFECT THE OUTLINE OF COVERAGE ON FILE FOR THE PRODUCT THIS APPLICATION IS UTILIZED WITH.		
Comments:			
Satisfied - Item:	REDLINED REVISED		

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APPLICATION

Comments:

The application has been revised so that it more closely matches the terms used in the policy's schedule of benefits. No other revisions have been made other than those highlighted on the attached form.

Attachment:

REDLINED rev AR app.pdf

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
ONE MOODY PLAZA
GALVESTON, TEXAS

READABILITY CERTIFICATION

We hereby certify that form ANL-GAPAPP6(AR) has (have) achieved a Flesch scale readability score that meets the minimum reading ease score as required by the state of Arkansas.



James P. Stelling
Vice President, Health Compliance

Date: September 15, 2011

**Application to
American National Life Insurance Company of Texas • P.O. Box 696870 • San Antonio, Texas 78269**

Please Print - Use Black Ink New Policy Reinstatement Existing #: _____ Change Existing _____

1. Special Requests: Mail Policy to Applicant: Yes No Requested Effective Date: _____

2. Please print the full name of all Proposed Insureds (use additional sheet and attach if needed).

Last, First, Middle Initial	Occupation	Relationship	Sex M/F	Date of Birth	Age	Height	Weight	Social Security Number
1.		Applicant						
2.		Spouse						
3.								
4.								
5.								
6.								

3. Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cellular: (____) _____ Email Address: _____

I am applying for:

4. Base Plan Daily Benefit Amount: \$ 100 \$ 250 \$ 500 AD&D Beneficiary: _____
 Emergency Room Benefit: \$ 250 \$ 500 AD&D Beneficiary Relationship: _____
Initial Daily Benefit Period: 2 Days 5 Days 10 Days
Initial Daily Benefit Amount: \$ 250 \$ 500 \$ 1,000 \$ 1,500 \$ 2,000 \$ 2,500
 Base Plan Annual Premium: _____

Optional Benefits:

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Critical Illness Beneficiary: _____ Relationship _____

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Mode: Annual Quarterly Semi-Annual Monthly PAC List Bill Total Annual Premium: _____

Total Premium Collected with Application: _____

5. Does any Proposed Insured currently have more than one Medical Expense and/or Hospital Indemnity Policy with this or any other company)?..... Yes No

If Yes, please name company and give details in chart below:

Plan Type	Company	To Be Replaced?	Plan Type	Company	To Be Replaced?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

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6. Is any Proposed Insured or family member of the household an expectant mother or expectant father?..... Yes No

7. Within the past 2 years, has any Proposed Insured had symptoms, treatment, or been recommended to have treatment for: Alcohol or Drug Abuse, Alzheimer's, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Ulcerative Colitis, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins Disease, End Stage Renal Disease, Leukemia, Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's Disease, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)?..... Yes No

8. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other Immune Disorder?..... Yes No

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