

SERFF Tracking Number: AMNA-127203858 State: Arkansas  
Filing Company: American National Life Insurance Company of Texas State Tracking Number: 49016  
Company Tracking Number: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH  
TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life  
Product Name: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH  
Project Name/Number: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH/ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH

## Filing at a Glance

Company: American National Life Insurance Company of Texas

Product Name: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH SERFF Tr Num: AMNA-127203858 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 49016

Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Tyra Reed, Tobie Brink

Disposition Date: 06/14/2011

Date Submitted: 06/08/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH

Status of Filing in Domicile: Pending

Project Number: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/14/2011

State Status Changed: 06/14/2011

Deemer Date:

Created By: Tobie Brink

Submitted By: Tobie Brink

Corresponding Filing Tracking Number:

Filing Description:

June 8, 2011

Arkansas Insurance Department

Compliance - Life and Health

1200 West Third Street

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Little Rock AR 72201-1904

RE: American National Life Insurance Company of Texas (NAIC: 71773 FEIN: 75-1016594) Filing Of:  
ANL-SME – Statements to Medical Examiner  
ANL-CSH – Certificate Statement of Health  
SERFF Tracking Number: AMNA-127203858  
Company Tracking Number: ANTEX STMT TO MED EXAM/CERT STMT OF HEALTH

Dear Reviewer:

Please find attached the above referenced forms for your department's review and approval. These are new forms and will not replace any previously filed forms. These forms will be used with individual life insurance products approved by your department on 4/14/2011 via SERFF tracking numbers AMNA-127025091 and AMNA-127032750.

ANL-SME – This form is the Statements to Medical Examiner form. During the underwriting process, additional information may be required. This form is completed by the proposed insured and the proposed insured's physician and returned to the administrative office. A copy of the completed form will be attached to and made a part of the application/policy.

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

- Statement of Variability for the forms
- Certificate of Readability
- Payment of any required filing fee
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

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Sincerely,

Tobie Brink  
 Life Policy Analyst III

## Company and Contact

### Filing Contact Information

Tobie Brink, Project Coordinator Tobie.Brink@ANICO.com  
 One Moody Plaza 409-763-1112 [Phone] 4165 [Ext]  
 Actuarial Product Development 409-766-6933 [FAX]  
 14th Floor  
 Galveston, TX 77550

### Filing Company Information

American National Life Insurance Company of Texas CoCode: 71773 State of Domicile: Texas  
 One Moody Plaza Group Code: 408 Company Type: Life, Health, Annuity  
 Galveston, TX 77550 Group Name: State ID Number:  
 (409) 763-4661 ext. 5222[Phone] FEIN Number: 75-1016594  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? Yes  
 Fee Explanation: 2 forms - non-exempt, no policy present @ 100 per form.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Life Insurance Company of	\$200.00	06/08/2011	48466813

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Texas

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/14/2011	06/14/2011

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## Disposition

Disposition Date: 06/14/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Variability		Yes
Form	Statements to Medical Examiner		Yes
Form	Certificate Statement of Health		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ANL-SME	Other	Statements to Medical Examiner	Initial		51.200	ANL-SME.pdf
	ANL-CSH	Other	Certificate Statement of Health	Initial		53.300	ANL-CSH.pdf



Statements to Medical Examiner

Issued by American National Life Insurance Company of Texas [One Moody Plaza, Galveston, TX 77550-7947 ]

Mailing Address: [PO Box 696700, San Antonio, TX 78269-6700 ] Business[(800) 899-6806 ] Fax[(888) 237-1012 ]



1. Proposed Insured's Name: Last, First, M.I. Date of Birth (Mo-Day-Yr) Sex: M F

Name, address, and phone number of personal physician (If none, state "none") Name of doctor: Date last seen: Address/Phone: Reason for last visit:

2. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession ... YES NO Give full details below of all "Yes," answers to questions 2 through 11. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICATION ITEMS: Include diagnosis dates, duration and names and addresses of all attending physicians and medical facilities.) Attach an additional sheet of paper, if necessary. 3. Have you, in the last ten years, been diagnosed or treated by a member of the medical profession for ... a) Seizures, epilepsy, or convulsions? b) Multiple Sclerosis (MS), ALS (Lou Gerhig's disease), muscular dystrophy, or Parkinson's disease? c) Asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD), or any disease or abnormality of the respiratory system? d) Cirrhosis, hepatitis, ulcerative colitis, Crohn's disease, disease of the pancreas, esophagus, ulcer or any other disease or disorder of the stomach or intestines? e) Anemia, blood disorder, clotting or bleeding disorder, or any lymph node disorder? f) Arthritis, fibromyalgia, or any disease of the bones, muscles or joints? g) Lupus, rheumatoid arthritis, scleroderma, polymyositis, dermatomyositis or any connective tissue disease? h) Injuries associated with falls or imbalance? i) Disease of the prostate or genital system? j) Disease of the kidneys, bladder, urinary tract, protein or blood in the urine? k) Depression, anxiety, psychiatric treatment or counseling, or any disease or abnormality of the brain or nervous system? 4. Within the past 10 years have you ... a) Been advised by a member of the medical profession to reduce or discontinue use of alcohol or drugs? b) Received treatment or counseling by a member of the medical profession for the use of alcohol or drugs? 5. Within the past 5 years have you ... a) had an operation or been hospitalized by a member of the medical profession for any illness, disease or accident? b) had any diagnostic testing by a member of the medical profession (EKG or other cardiovascular test, X-ray, blood, or other laboratory test)? 6. Are you currently being prescribed any medications or under any treatment by a member of the medical profession? (please list medications/treatment) 7. Has your weight changed by more than 10 lbs in the past year? If yes, reason?





American National Life Insurance  
Company of Texas

**MEDICAL EXAMINER'S REPORT**

**This examination should be made in private. If 3rd person present, give details.**

12.	Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, At Umbilicus Relaxed	DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS.)
	Ft. In.	Lbs.	In.	In.	In.	

Did you weigh?  Yes  No Did you measure?  Yes  No  
 Weight change in the past year \_\_\_\_\_ lbs.  Gain  Loss, Cause? \_\_\_\_\_  
 Is appearance unhealthy or older than stated age?  Yes  No

Attach an additional sheet of paper, if necessary.

13. BLOOD PRESSURE: All readings must be taken in a sitting position. If first reading is over 140/90 make two additional observations at 10 minute intervals.

	Rest	2nd	3rd
Systolic			
Diastolic (5th Phase)			

14. Pulse Rate:	Before Exercise	Immediately After	Three Minutes After
Pulse Rate			
Irregularities			

15. Heart: (a) Is there any evidence of cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? Yes  No
- (b) Is there any history of Rheumatic fever?  Yes  No
- (c) Is heart enlarged? (If yes, describe)  Yes  No
- (d) Is murmur present? (If yes, complete 12e)  Yes  No
- (e) Murmur is:  Systolic  Apical  Soft (Gr. 1-2)  
 Constant  Transmitted  Presystolic  Basal  Mod. (Gr. 3-4)  
 Inconstant  Localized  Diastolic  Other  Loud (Gr. 5-6)  
 After exercise is murmur:  Unchanged  Increased  Decreased  Absent

(f) If more than one murmur is present, explain under details at right.

Show location of:  
 Apex by **X**  
 Area of murmur by   
 Point of greatest intensity by   
 Transmission by  $\rightarrow$



Your diagnosis of any cardiovascular abnormality \_\_\_\_\_

- |     |   |                          |                          |
|-----|---|--------------------------|--------------------------|
| 16. | Is there on examination any abnormality of the following: (Circle applicable items and give details.)                         | Yes                      | No                       |
|     | (a) Eyes, ears, nose, mouth, pharynx, (if vision or hearing is markedly impaired, indicate degree and correction.)            | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (b) Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins)   | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (c) Nervous system (include reflexes, gait, paralysis)  | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (d) Respiratory system  | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (e) Abdomen (including scars or hernia)   | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (f) Genito-Urinary system (include prostate)  | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (g) Endocrine system (include thyroid and breasts)  | <input type="checkbox"/> | <input type="checkbox"/> |
|     | (h) Musculoskeletal system (include spine, joints, amputations, deformities)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | Have you any pertinent information not found on examination or brought out in statements to medical examiner on reverse side? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | Are you related to the person examined or the Agent/Insurance Producer?   | <input type="checkbox"/> | <input type="checkbox"/> |



American National Life Insurance  
Company of Texas

19. URINALYSIS: (To be done in all cases.)  
Send specimen to laboratory in all cases. Specific Gravity: \_\_\_\_\_ Alb. \_\_\_\_\_ Sugar \_\_\_\_\_

**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.

I certify that I examined \_\_\_\_\_ at \_\_\_\_\_ A.M./P.M. on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(Name of Applicant) Month Year

Examination made at my office \_\_\_\_\_, Individual's office \_\_\_\_\_, Individual's home \_\_\_\_\_, other \_\_\_\_\_

Examiner's Signature: \_\_\_\_\_, Examiner's Address: \_\_\_\_\_

SS#    or Tax I.D.#

**EXAMINER'S VOUCHER**

(Do not detach)

Medical Examiner \_\_\_\_\_

SS#    or Tax I.D.#

Fee \$ \_\_\_\_\_

Address of Examiner \_\_\_\_\_

Name of Person examined \_\_\_\_\_

Name of Agent/Insurance Producer \_\_\_\_\_ Agency \_\_\_\_\_

Date of Examination \_\_\_\_\_

# Certificate Statement of Health

Issued by American National Life Insurance Company of Texas  
[ One Moody Plaza, Galveston, TX 77550-7947 ] Phone Number [ (800) 899-6806 ]



**PLEASE RETURN TO THE LIFE NEW BUSINESS DEPARTMENT AT THE ADDRESS PROVIDED BELOW:**

**American National Life Insurance Company of Texas - Administrative Offices**  
**ATTN: Life New Business Dept.**  
**[ PO Box 1890**  
**Galveston, TX 77553-1890 ]**

To AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, Galveston, Texas:

For:

Policy Number: \_\_\_\_\_

Insured: \_\_\_\_\_

Amount of Insurance: \_\_\_\_\_

## APPLICANT'S CERTIFICATION STATEMENT OF HEALTH

**(check the appropriate statement)**

- I declare that all statements made and answers given in the application and medical examination(s), if any, for the policy were complete and true when made and continue to be complete and true as of today's date.
- The statements made and answers given in the application and medical examination(s), if any, for the policy were complete and true when made, but are no longer a true representation of the Insured's current health condition as of today's date. By checking this box, I understand that the Insured's coverage under this policy may be affected. I have provided, in the section marked DETAILS below, details regarding the change in the Insured's health condition since the date of my original application.

DETAILS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Please check here if you have provided additional details on the back of this form, or if you are providing additional details on an attached sheet.

This is to acknowledge that I have received my Policy and the illustration of values (if applicable).

I understand and agree that this Certificate Statement of Health will be attached to and made a part of the application for which the above policy was issued

## FRAUD STATEMENT

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.

I understand that this form shall form a part of my application for insurance with American National Life Insurance Company of Texas.

Dated at \_\_\_\_\_  
(City) (State)

Date \_\_\_\_\_  
(Month/Day/Year)

Signed \_\_\_\_\_  
Insured (Or guardian, if Insured is under age 16)

Signed \_\_\_\_\_  
Applicant/Owner if other than the Insured

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Stmts to Med Exam-Cert Stmt of Health Generic Readability Certification.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> This is not a policy/product filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Life & Annuity - Acturial Memo		
<b>Bypass Reason:</b> This is not a policy/product filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter		
<b>Comments:</b>		
<b>Attachment:</b> AR.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Variability		
<b>Comments:</b>		

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**Attachment:**

MVM - Stmt to Medical Exam-Cert Stmt of Health Generic.pdf



AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

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## READABILITY CERTIFICATION

We hereby certify that the following form(s), meet the requirements of the Readability Insurance Policies

Act:

<u>Form</u>	<u>Form Name</u>	<u>Scoring(s)</u>
ANL-SME	Statements to Medical Examiner	51.2
ANL-CSH	Certificate Statement of Health	53.3

Rex D. Hemme

Senior Vice President & Actuary

American National Life Insurance Company of Texas

6/8/2011



Tobie Brink, Life Policy Analyst III  
Product Development – Actuarial  
Home Office : One Moody Plaza, 14<sup>th</sup> Floor  
Galveston, Texas 77550

e-mail: [tobie.brink@anico.com](mailto:tobie.brink@anico.com)  
Phone: (409) 763-4661 x 4265  
Fax: (409) 766-6933

June 8, 2011

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

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Sincerely,

*Tobie Brink*

Tobie Brink  
Life Policy Analyst III

## American National Life Insurance Company of Texas

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June 7, 2011

### MEMORANDUM OF VARIABLE MATERIAL FOR:

- ANL-SME
- ANL-CSH

This memorandum was prepared for use with the forms listed above by American National Life Insurance Company of Texas.

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

#### Variable Material

ANL-SME - The form contains the following permissible variable material:

Home Office Address  
Mailing Office Address  
Business (telephone number)  
Business (fax number)

ANL-CSH - The form contains the following permissible variable material:

Home Office Address  
Business (telephone number)  
PO Box Address - Administrative Offices

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.

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.