

SERFF Tracking Number: AMNA-127298041 State: Arkansas
Filing Company: American National Insurance Company State Tracking Number: 49170
Company Tracking Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES
Project Name/Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES/ANICO MEDICAL STATEMENTS/QUESTIONNAIRES

Filing at a Glance

Company: American National Insurance Company

Product Name: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES SERFF Tr Num: AMNA-127298041 State: Arkansas

TOI: L071 Individual Life - Whole SERFF Status: Closed-Approved- Closed State Tr Num: 49170

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Authors: Tyra Reed, Tobie Brink Disposition Date: 07/05/2011

Date Submitted: 06/29/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES Status of Filing in Domicile: Pending

Project Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES 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: 07/05/2011

State Status Changed: 07/05/2011

Deemer Date: Created By: Tobie Brink

Submitted By: Tobie Brink Corresponding Filing Tracking Number:

Filing Description:

Arkansas Insurance Department

Compliance - Life and Health

1200 West Third Street

Little Rock AR 72201-1904

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

SERFF Tracking Number: AMNA-127298041 State: Arkansas
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AN-SME Statements to Medical Examiner
Form 10394 Certificate Statement of Health
AN-MIL-AR Military Status Questionnaire
AN-FOR-AR Foreign Travel Questionnaire
AN-DIA-AR Diabetic Questionnaire
AN-DIS-AR Disabled Applicant Questionnaire
AN-EPI-AR Epilepsy/Seizure Questionnaire
AN-SCU-AR Scuba Diving Questionnaire
AN-RES-AR Respiratory Questionnaire
AN-BLO-AR Blood Pressure Questionnaire
AN-HBP-AR High Blood Pressure Questionnaire
AN-DRU-AR Drug Use Questionnaire
AN-ALC-AR Alcohol Use Questionnaire
AN-CUP-AR Check Up Questionnaire
AN-AVI-AR Aviation Questionnaire
AN-MOT-AR Motor Sports Questionnaire
AN-SPO-AR Sports, Amusement or Avocation Questionnaire
AN-RAC-AR Racing Questionnaire
AN-CPA-AR Chest Pain Questionnaire
Form 4544-AR Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates and Preferred Plus Rates

SERFF Tracking Number: AMNA- 127298041

Company Tracking Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES

Dear Reviewer:

Please find attached the above referenced forms for your department's review and approval. These forms will be used with approved individual life insurance products.

AN-SME-AR – This form is the Statements to Medical Examiner form. This form will replace previously approved form 9928 1/88 approved on 2/3/88. 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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10394-AR – This form is the Certificate Statement of Health. This is a new form and will not replace any previously approved form. The Authorization section of the application requires that the applicant be in the same health condition as described in the application when the policy is delivered in order for the policy to be effective. This form will be provided to the applicant at the time of policy delivery and will be required to be signed and returned before the policy becomes effective. A completed copy of the form will be provided to the Owner for attachment to the application/policy.

Medical Questionnaires – These forms will replace previously approved forms via SERFF tracking number AMNA-125968137 approved on 3/2/09. Within the application, there is medical history and other similar type questions used to assist us in determining the insurability and risk class of the applicant. For some of these questions, a ‘yes’ answer will prompt the use of a supplemental questionnaire in order to gather more information. In addition to a ‘yes’ answer, the underwriter can request the completion of a supplemental questionnaire at their discretion, usually based on findings in a report or medical examination on the applicant obtained during the underwriting process. When used, these questionnaires will be attached to and considered a part of the application, which is attached to and made a part of the policy.

These questionnaires will be used with all current and future approved life insurance applications, insurability, and reinstatement applications.

Form 4544-AR – This form is the Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates and Preferred Plus Rates. This is a new form and will not replace any previously approved form. It is used when there are more than two adults applying for coverage on one application to provide the family history of the additional adults. It is also used when requesting a change to preferred rates on a policy change.

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.

Company and Contact

Filing Contact Information

Tobie Brink, Project Coordinator
One Moody Plaza

Tobie.Brink@ANICO.com
409-763-1112 [Phone] 4165 [Ext]

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Actuarial Product Development 409-766-6933 [FAX]
 14th Floor
 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: \$2,000.00
 Retaliatory? Yes
 Fee Explanation: 20 forms - non-exempt, no policy present @ 100 per form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	\$2,000.00	06/29/2011	49234482

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/05/2011	07/05/2011

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Disposition

Disposition Date: 07/05/2011

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 - Actuarial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Statement of Variability		Yes
Form	Statements to Medical Examiner		Yes
Form	Certificate Statement of Health		Yes
Form	Military Status Questionnaire		Yes
Form	Foreign Travel Questionnaire		Yes
Form	Diabetic Questionnaire		Yes
Form	Disabled Applicant Questionnaire		Yes
Form	Epilepsy/Seizure Questionnaire		Yes
Form	Scuba Diving Questionnaire		Yes
Form	Respiratory Questionnaire		Yes
Form	Blood Pressure Questionnaire		Yes
Form	High Blood Pressure Questionnaire		Yes
Form	Drug Use Questionnaire		Yes
Form	Alcohol Use Questionnaire		Yes
Form	Check Up Questionnaire		Yes
Form	Aviation Questionnaire		Yes
Form	Motor Sports Questionnaire		Yes
Form	Sports, Amusement and Avocation Questionnaire		Yes
Form	Racing Questionnaire		Yes
Form	Chest Pain Questionnaire		Yes
Form	Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates, and Preferred Plus Rates		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
	AN-SME	Application/ Statements to Enrollment Medical Examiner Form	Initial		51.200	AN-SME.pdf
	Form 10394	Application/ Certificate Statement Enrollment of Health Form	Initial		53.300	Form 10394.pdf
	AN-MIL-AR	Application/ Military Status Enrollment Questionnaire Form	Initial		66.500	AN-MIL-AR.pdf
	AN-FOR-AR	Application/ Foreign Travel Enrollment Questionnaire Form	Initial		57.900	AN-FOR-AR.pdf
	AN-DIA-AR	Application/ Diabetic Enrollment Questionnaire Form	Initial		61.200	AN-DIA-AR.pdf
	AN-DIS-AR	Application/ Disabled Applicant Enrollment Questionnaire Form	Initial		50.900	AN-DIS-AR.pdf
	AN-EPI-AR	Application/ Epilepsy/Seizure Enrollment Questionnaire Form	Initial		61.500	AN-EPI-AR.pdf
	AN-SCU-AR	Application/ Scuba Diving Enrollment Questionnaire Form	Initial		57.900	AN-SCU-AR.pdf
	AN-RES-AR	Application/ Respiratory Enrollment Questionnaire Form	Initial		62.100	AN-RES-AR.pdf
	AN-BLO-AR	Application/ Blood Pressure Enrollment Questionnaire Form	Initial		60.300	AN-BLO-AR.pdf

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AN-HBP-AR	Application/ High Blood Pressure Initial Enrollment Questionnaire Form		68.700	AN-HBP-AR.pdf
AN-DRU-AR	Application/ Drug Use Initial Enrollment Questionnaire Form	Initial	55.900	AN-DRU-AR.pdf
AN-ALC-AR	Application/ Alcohol Use Initial Enrollment Questionnaire Form	Initial	52.100	AN-ALC-AR.pdf
AN-CUP-AR	Application/ Check Up Initial Enrollment Questionnaire Form	Initial	50.700	AN-CUP-AR.pdf
AN-AVI-AR	Application/ Aviation Initial Enrollment Questionnaire Form	Initial	57.800	AN-AVI-AR.pdf
AN-MOT-AR	Application/ Motor Sports Initial Enrollment Questionnaire Form	Initial	66.500	AN-MOT-AR.pdf
AN-SPO-AR	Application/ Sports, Amusement and Avocation Initial Enrollment Questionnaire Form	Initial	50.700	AN-SPO-AR.pdf
AN-RAC-AR	Application/ Racing Initial Enrollment Questionnaire Form	Initial	62.100	AN-RAC-AR.pdf
AN-CPA-AR	Application/ Chest Pain Initial Enrollment Questionnaire Form	Initial	77.800	AN-CPA-AR.pdf
Form 4544-AR	Application/ Supplemental Enrollment Questionnaire for Form Consideration of Standard Plus, Preferred Rates, and Preferred Plus Rates	Initial	54.900	form 4544-AR.pdf



Statements to Medical Examiner

Issued by American National Insurance Company
[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 _____ Date of Birth (Mo-Day-Yr) _____ Sex: M F
 Name: First, M.I. _____

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.
a) for a heart attack, chest pain, angina, congestive heart failure, heart murmur, irregular heart beat, heart valve disease or any disease or disorder of the heart or arteries?	<input type="checkbox"/>	<input type="checkbox"/>	
b) for a stroke, cerebral vascular accident (CVA), Transient Ischemic Attack (TIA), aneurysm, or peripheral vascular disease (PVD)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) for cancer, leukemia, lymphoma, malignant melanoma or any other malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	
d) for diabetes, elevated blood sugar, impaired glucose intolerance or impaired fasting glucose?	<input type="checkbox"/>	<input type="checkbox"/>	
e) for human immunodeficiency virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Multiple Sclerosis (MS), ALS (Lou Gerhig's disease), muscular dystrophy, or Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD), or any disease or abnormality of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Anemia, blood disorder, clotting or bleeding disorder, or any lymph node disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
f) Arthritis, fibromyalgia, or any disease of the bones, muscles or joints?	<input type="checkbox"/>	<input type="checkbox"/>	
g) Lupus, rheumatoid arthritis, scleroderma, polymyositis, dermatomyositis or any connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>	
h) Injuries associated with falls or imbalance?	<input type="checkbox"/>	<input type="checkbox"/>	
l) Disease of the prostate or genital system?	<input type="checkbox"/>	<input type="checkbox"/>	
j) Disease of the kidneys, bladder, urinary tract, protein or blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>	
k) Depression, anxiety, psychiatric treatment or counseling, or any disease or abnormality of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Received treatment or counseling by a member of the medical profession for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
b) had any diagnostic testing by a member of the medical profession (EKG or other cardiovascular test, X-ray, blood, or other laboratory test)?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are you currently being prescribed any medications or under any treatment by a member of the medical profession? (please list medications/treatment)	<input type="checkbox"/>	<input type="checkbox"/>	
7. Has your weight changed by more than 10 lbs in the past year? If yes, reason?	<input type="checkbox"/>	<input type="checkbox"/>	



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 Insurance Company
[One Moody Plaza, Galveston, TX 77550-7947]



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

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

To AMERICAN NATIONAL INSURANCE COMPANY, 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 Insurance Company.

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



Military Status Questionnaire
Issued by American National Insurance Company
[One Moody Plaza, Galveston, TX 77550-7947]

page 1 of 1

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



Name _____ File # _____

- 1) Of what branch of service are you a member? _____
- 2) Present duty status? Active Active Reserve Inactive Reserve National Guard ROTC
- 3) Present rank: _____
- 4) Present unit: _____
- 5) Military occupational specialty: _____
- 6) Address of present unit: _____
- 7) Present assignment: _____
- 8) To your knowledge, have you been told or are you aware that:
 - a) You will be transferred overseas? Yes No
If Yes, where? _____
 - b) You or your unit will be alerted for duty (if presently in the Reserve or National Guard)? Yes No

Fraud Warning

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.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this military history.



Foreign Travel Questionnaire

Issued by American National Insurance Company
[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]



Name _____ File # _____

Please provide details of foreign travel including holidays and short business trips within the last two (2) years.

1. Within the last two (2) years:

Date(s) of Visit(s)	Countries	Regions	Reason for Visit(s)	Duration of Visit(s)

2. Future Intentions: (limited to two (2) years)

Date(s) of Visit(s)	Countries	Regions	Reason for Visit(s)	Duration of Visit(s)

3. Please give a brief description of your duties while traveling or residing abroad. _____

4. Do you expect to visit non-urban areas? Yes No

If Yes, please give details of:

a) Your probable accommodations: _____

b) The availability of medical facilities: _____

c) Your travel arrangements (example: Light Aircraft, Boat): _____

5. Are you a U.S. Citizen: Yes No

If No, of what country are you now a citizen? _____

What visa do you hold? Permanent Temporary Expiration date: _____

6. Do you maintain a foreign residence? Yes No

If Yes, please provide address: _____

How often do you visit this residence? _____

What is the duration of typical stay or visit? _____

Fraud Warning

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.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this foreign travel history.



Diabetic Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

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

2. Type of treatment? Insulin Oral Medication Diet only

Type of insulin and/or oral medication: _____

Dosage and frequency: _____

3. Do you follow a diabetic diet? Yes No

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

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

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

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

If Yes, when? _____

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

If Yes, explain: _____

9. Have you been diagnosed by a member of the medical profession as having any visual problems (other than corrective lenses), heart or circulatory problems, albumin or protein in your urine, loss of consciousness, or numbness or tingling in your feet or legs?
 Yes No

If Yes, explain: _____

10. How many days have you lost from work due to diabetes in the last two (2) years? _____

If any time off from work was due to diabetes in the past two (2) years, provide details including dates and duration of time off from work: _____

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

Date of last consultation? _____

Fraud Warning

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.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this diabetic history.



Disabled Applicant Questionnaire

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

page 1 of 1

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



Name _____ File # _____

1. What disability have you been diagnosed, treated, tested positive for, or been provided medical advice for by a member of the medical profession? _____

2. As diagnosed by a member of the medical profession, when was the onset of the disability? _____

3. Was there a cause for the above diagnosed disability? _____

4. Does the above diagnosed disability affect your ability to work or carry out normal daily activities including bathing, dressing, grooming and homemaking? Yes No

If yes, give details _____

5. What was your job prior to your disability? _____

6. When do you expect to return to work? _____

7. Are you currently receiving Worker's Compensation, Unemployment or Disability payments? Yes No

8.

Name, Address, Phone No. Physician & Hospitals	Conditions and Details	Date	How Often Seen

9. Additional Remarks: _____

Fraud Warning

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.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this disabled history.



Epilepsy/Seizure Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

1. Date diagnosed by a member of the medical profession: _____

2. Type of seizure disorder (if known): absence/petite mal tonic clonic/grand mal other: _____

3. Has a cause been determined by a member of the medical profession? _____

4. Have you had any CT-scans or MRI's of the brain in the past year? Yes No

If Yes, what were the results? _____

Name, address and phone number of the hospital/clinic/physician that would have a copy of this test:

5. Number of seizures or convulsions per year: _____

6. Date of the last seizure or convulsion: _____

7. Please list medications currently used for seizures including dosage, and how often taken: _____

8. If no longer on medication, when did you discontinue treatment and was the medication discontinued at the advice of a medical professional? _____

9. Name, address, and phone number of the doctor who would have the most current and complete information about your condition:

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this epilepsy/seizure history.



Scuba Diving Questionnaire

Issued by American National Insurance Company
[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]



Name _____ File # _____

1. Level of certification? basic open water advance open water master diver dive master instructor
 other: _____
2. a) What are the locations of your diving activities? (example: cave, under ice, inland waters, ocean, ship wrecks) _____

- b) If you are a cave diver, are you certified by NACD (National Association for Cave Diving or NASDS (National Association of Scuba Diving Schools)? Yes No
- c) Do you ever participate in any night diving? Yes No
3. Are you currently certified by one of the national training and certification organizations? Yes No
Name of the organization(s)? _____
4. Are you a member of an organized club? Yes No
5. Do you ever dive alone? Yes No
6. Do you dive or do you contemplate diving for compensation within the next two (2) years? Yes No
7. Do you ever dive for depth records? Yes No
8. Do you ever dive using experimental equipment? Yes No

IF "YES" FOR ANY OF THE ABOVE, PLEASE GIVE DETAILS BELOW UNDER "REMARKS".

9. Particulars of diving:

Depth of Dive	Past 12 Months No. of Dives	Avg. Time Under Water per Dive	Expected Next 12 Months No. of Dives
To 50 ft. or less	_____	_____	_____
To 75 ft.	_____	_____	_____
To 100 ft.	_____	_____	_____
To 150 ft.	_____	_____	_____
To 200 ft.	_____	_____	_____
Over 200 ft.	_____	_____	_____
Date of last dive: _____			

10. REMARKS: _____

Fraud Warning

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.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this scuba diving history.



Respiratory Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

1. a) Have you been diagnosed by a member of the medical profession as having: bronchitis asthma emphysema
 chronic cough wheezing chronic obstructive pulmonary disease pneumonia shortness of breath
 other (explain): _____

b) Has the cause been determined by a member of the medical profession? _____

2. How often does the condition indicated above occur? _____

3. Date of last occurrence as documented by a member of the medical profession: _____

4. Are the occurrences considered Mild Moderate Severe as documented by a member of the medical profession?

5. As diagnosed by a member of the medical profession, indicate the pattern of your attacks in the past five (5) years:

no change in symptoms improvement in symptoms increasing symptoms or more severe attacks

6. Have you lost time from work? Yes No If Yes, when, how long, and why? _____

7. In the past five (5) years, have you been hospitalized for a respiratory disorder diagnosed by a member of the medical profession?

Yes No If Yes,

Hospital	City, State & ZIP	Approximate date(s)

8. Provide the name(s) of the medications or types of treatments as prescribed or performed by a member of the medical profession for the respiratory conditions(s) indicated: _____

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

9. Has a member of the medical profession performed any pulmonary function studies or tests? Yes No

If Yes, date and results: _____

10. Do you use tobacco in any form? Yes No If Yes, type and amount per day: _____

If used in the past and quit, number of years, quantity and date of last use. _____

11. Have you been prescribed or provided medical advice by a member of the medical profession to use supplemental oxygen?

Yes No

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this respiratory history.



Blood Pressure Questionnaire

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

page 1 of 1

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



Name: _____ Birthdate: _____ File #: _____

1. What was your highest blood pressure reading? _____ Please provide the date of this reading: _____

2. What was your lowest blood pressure reading? _____ Please provide the date of this reading: _____

3. Have you received treatment from a member of the medical profession for blood pressure? _____ If "yes:"

A. Name, address and phone number of doctor(s): _____

B. When did treatment begin? _____

C. Last blood pressure reading and date of visit: _____

D. Medication(s) prescribed and dosage: _____

4. Have you been diagnosed or treated by a member of the medical profession for any of the following?

- Stroke
- Severe headaches
- High cholesterol
- Heart Disease
- Diabetes
- Chest pains
- Circulation problems
- Other

Please provide details. _____

5. Have you had any special studies performed by a member of the medical profession: (X-Rays, EKG, Lab Tests, etc.)? If yes, please provide the results: _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this blood pressure history.



High Blood Pressure Questionnaire

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

page 1 of 1

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



Name _____ File # _____

- 1) When was high blood pressure first diagnosed? _____
- 2) Within the last five (5) years, have you had an electrocardiogram (EKG), cardiac stress test, echocardiogram, or other heart or blood vessel study completed? Yes No
- 3) Other than monitoring, has any treatment or medication been prescribed or recommended as a result of the tests in question 2? Yes No
- 4) How many days have you lost from work or been unable to perform your usual daily activities due to high blood pressure within the last two (2) years? _____
- 5) What was the date and reading of your last blood pressure test? Date: _____ Reading: _____
- 6) Within the last six (6) months has your blood pressure exceeded either 160 systolic (the upper number) or 100 diastolic (the lower number)? Yes No
- 7) What is the name and address (city/state) of the medical professional you consult for high blood pressure?
Name of medical professional: _____ City: _____ State: _____
- 8) When did you last visit this medical professional? Month: _____ Year: _____
- 9) What medications have been prescribed for treatment of your high blood pressure? _____
- 10) Are there any medications above that you are not currently taking? Yes No If Yes, what medications: _____

Fraud Warning

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.

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature

Date



Drug Use Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

- | | | |
|---|--------------------------|--------------------------|
| 1. Do you use or have you used: | Yes | No |
| a) Narcotics (example: codeine, heroin, morphine, opium, methadone, demerol, percodan, dilaudid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Hallucinogens (example: lysergic acid diethylamide (LSD), mescaline, phencyclidine (PCP), peyote)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Cannabis (example: marijuana, hashish, tetrahydrocannabinol (THC))? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Stimulants (example: cocaine, crack, benzedrine, methamphetamine, amyl nitrite)? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Sedatives (example: tuinal, seconal, nembutal)? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Tranquilizers (example: librium, valium, diazepam, halcion, quaalude)? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) I.V. (intravenous - injected by needle into blood vein) Drug use. | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Any other substance abuse? | <input type="checkbox"/> | <input type="checkbox"/> |

2. If Yes for any of the above, please give details below:

Drug Used	Frequency (No. of times per week)	Dates Used From (mo/yr) To (mo/yr)	Name and Address of Prescribing Physician (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Have you ever been suspended or terminated from employment due to drug related causes? Yes No
If Yes, give details: _____
4. a) Have you ever sought, received, or been advised to receive treatment because of your drug use? Yes No
If Yes, indicate number of times treated _____, date(s) of treatment _____, name, address, and phone number of any doctor, hospital, or treatment center involved. _____
- b) Have you ever been diagnosed or treated by a member of the medical profession for any medical complications as a result of drug use? Yes No If Yes, explain: _____
5. Have you ever plead guilty to or been charged with any offense involving drugs, including driving under the influence of drugs or alcohol? Yes No If Yes, give details and driver's license number: _____
6. Do you or have you attended Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or any 12-step program or support group for alcohol or drugs? Yes No If Yes, date first attended: _____ Date last attended: _____
7. Please add any additional information which you feel is important concerning your use of drugs: _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this drug use history.



Alcohol Use Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Driver's License # _____ State Issued _____

File # _____

1. Do you presently use or have you in the past used alcoholic beverages? Yes No

	PRESENT USE OF ALCOHOL				PAST USE OF ALCOHOL			
	Quantity Used	Frequency (Daily, Weekly, Monthly)	Dates Used From: To:		Quantity Used	Frequency (Daily, Weekly, Monthly)	Dates Used From: To:	
Beer								
Wine								
Other Alcohol								

2. Have you changed your drinking habits? Yes No If Yes, why? _____

3. Have you ever consulted or been advised to consult, a hospital, physician or practitioner, or received treatment for your alcohol use? Yes No If Yes, date: _____

Treatment Center/Doctor's Name: _____

Address: _____ City and state: _____ ZIP: _____ Phone #: _____

4. Are you presently being treated by a member of the medical profession for alcohol use? Yes No

5. Are you attending or have you ever attended any alcohol related, self-help organizations (example: Alcoholic Anonymous)?

Yes No If Yes, last date attended: _____

Name of organization: _____ How often do you attend? _____

Date of first attendance: _____ Do you still attend meetings? Yes No

6. Have you ever been convicted for driving while under the influence of alcohol? Yes No

If Yes, number of times: _____ Date(s): _____

7. Have you ever been suspended or terminated from employment due to alcohol related causes? Yes No

If Yes, furnish details: _____

8. Have you ever been diagnosed by a member of the medical profession with or treated for any medical complications as a result of alcohol use? Yes No If Yes, conditions such as: Pancreatitis Gastritis Liver problems Other: _____

9. In the past five (5) years, have you used any drug or narcotic (except prescribed by a physician) or received treatment or counseling from a member of the medical profession for drug use? (Drugs include, but are not limited to: barbiturates, heroin, cocaine, opiates, amphetamines, marijuana and hallucinogens.) Yes No If Yes, please explain: _____

Furnish dates, name, address, and phone number of doctor(s) or medical facilities: _____

10. Please include any additional information which you feel is important.

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this alcohol use history.



Check-up Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

page 1 of 1

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



Name _____ File # _____

1. What was the purpose of the check-up? (Example: Employment, School, License Requirement, Health Related)

2. Diagnosis by member of medical profession:

Date of diagnosis by member of medical profession: _____

Treatment/medications prescribed by member of medical profession: _____

Name, address and phone number of attending physician: _____

3. Is any future testing, surgery, or treatment required or recommended by a member of the medical profession? Yes No

If Yes, provide details: _____

4. If referred to another physician or medical facility, provide name, address, and date of attendance: _____

5. Please include any additional information which you feel is important: _____

Fraud Warning

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Proposed Insured's Signature

Date

Please use the back of this sheet, if necessary, to report details which will clarify this check-up history.



Aviation Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

1. a) Type of certificate or license now held? Student — If student, when did the proposed insured first obtain a student pilot's certificate? _____
 Private Commercial ATR (Airline Transport Rating) Other (specify): _____
- b) Does the proposed insured have an instrument flight rating? Yes No
- c) Total number of hours flown as a pilot? _____
- d) What percentage of the proposed insured's flying time is
 - i) with a qualified co-pilot? _____
 - ii) in a single engine plane? _____
 - iii) in a multi-engine plane? _____
2. If not a pilot, specify the capacity in which the proposed insured flies. (example: flight surgeon, photographer, crew member): _____
3. a) When did the proposed insured last fly as a pilot or crew member? _____
 b) Type of aircraft? (specify alphabetic and numeric code, propeller or jet, and give brief description.)

4. Has the proposed insured flown, or does the Proposed Insured intend to fly outside the United States within the next two (2) years? Yes No
 If Yes, explain: _____
5. Has the proposed insured ever had an aircraft accident or been grounded, fined, or reprimanded for violation of air regulations? Yes No
 If Yes, give details: _____

Complete the following chart as it may apply

Type of Flying	Hours Contemplated Next 12 Months	Hours Past 12 Months	Hours One to Two Years Ago	Type of Flying	Hours Contemplated Next 12 Months	Hours Past 12 Months	Hours One to Two Years Ago
Commercial (Flying for pay) Scheduled Passenger Airline				Non-Commercial (Not Flying For pay) Pleasure			
Employer owned aircraft for employee transportation				Personal Business Transportation			
Other Freight Carrying or Passenger Service				Instruction As Student			
Student Instructor				Other (Ultralight, Glider, Etc)			
Crop Dusting/ Aerial Spraying							
Military							

If we find your flying activities involve an extra hazard that requires an exclusion or an extra premium charge, please indicate your choice.

- Policy to include aviation coverage at appropriate extra premium. Despite payment of an additional premium for aviation coverage on the base policy, the aviation exclusion included in any accidental death benefit rider which may be issued with or become part of, the policy will still be in effect.
- Policy to incorporate aviation exclusion rider.

Fraud Warning

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I declare the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this aviation history.



Motor Sports Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Driver's License # _____ State Issued _____

File # _____

1. Amateur Professional
2. Do you engage in exhibitions or organized competitive motor sports? Yes No
3. Check below each type(s) of event(s) you pursue. Please give details in remarks section below:

<input type="checkbox"/> All terrain (ATV) <input type="checkbox"/> Auto - crash <input type="checkbox"/> Auto - ice <input type="checkbox"/> Championship cars <input type="checkbox"/> Demolition or destruction derby <input type="checkbox"/> Drag racing <input type="checkbox"/> Dune/sand buggy or cycle <input type="checkbox"/> Economy runs <input type="checkbox"/> Figure 8 demolition derby <input type="checkbox"/> Football/auto football demolition derby or soccer <input type="checkbox"/> Formula racing <input type="checkbox"/> Gyro - stabilized land or water vehicles <input type="checkbox"/> Hill climb <input type="checkbox"/> Hovercraft and hydrofoils; amphibians <input type="checkbox"/> Jet car exhibitions <input type="checkbox"/> Kart racers	<input type="checkbox"/> Midget cars <input type="checkbox"/> Mini cars <input type="checkbox"/> Motorcycles <input type="checkbox"/> Off road, desert, trail competition <input type="checkbox"/> Rally <input type="checkbox"/> Scooters <input type="checkbox"/> Snowmobiles <input type="checkbox"/> Sports cars <input type="checkbox"/> Sprint cars <input type="checkbox"/> Stock cars <input type="checkbox"/> Time speed trials <input type="checkbox"/> Wheelie competitions <input type="checkbox"/> Others (explain in remarks below)
---	---

Types Of Races*	Maximum Speed	Last 12 Months		1-2 Years Ago		Prior to 2 Years Ago		Contemplated Next 12 Months	
		Races	Miles	Races	Miles	Races	Miles	Races	Miles

(*Midget, Sport Car, Stock-Car, Championship, Drag, Motorcycle)

4. What specific type of event do you compete in with the above vehicle(s)? (example: road race, endurance, sprint, motorcross)

5. Please furnish the following information:

a) What type of vehicle do you operate? _____	b) What make & model? _____
c) Is it modified? _____	d) What is the HP (horsepower)? _____
e) Engine size? _____	f) Engine displacement? _____
g) Class? _____	h) Type of fuel? (example: gas, nitro) _____
6. Under what sanctioning body do you normally compete? (Example: AMA (American Motorcyclist Association), NHRA (National Hot Rod Association), SCCA (Sports Car Club of America), USAC (United States Auto Club)) _____
7. Do you anticipate any changes in your participation in the coming twelve (12) months? If Yes, give details.
(example: Different events, new class) _____
8. Have you had any moving traffic violations in the past three (3) years? Yes No If Yes, please furnish details:

9. Remarks: _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this motor sports history.



Sports, Amusement, or Avocation Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

(Do not use for aviation, motor sports, racing, or scuba)

Instructions:

1. Answer each question with as much detail as possible. Additional information may be put on back.
2. If more than one sport or avocation is participated in, use separate questionnaire.
3. For Aviation use Aviation Questionnaire; for Scuba use Scuba Diving Questionnaire; for Motor Sports use Motor Sports Questionnaire; for Racing use Racing Questionnaire

Examples when form is required:

- Ballooning
- Bungee Jumping
- Hang Gliding
- Horse Racing
- Mountaineering
- Parachuting
- Powerboat Racing
- Rock Climbing
- Snowmobiling
- Spelunking

1. What is the activity in which you participate? _____

2. What national clubs or associations are you affiliated with in connection with this activity? _____

3. List any special licenses, professional or amateur titles you hold in connection with this activity: _____

4. Do you participate for monetary gain or profit? Yes No If Yes, give details: _____

Earnings: This year _____ Last year _____ 2 years ago _____ 3 years ago _____

5. In what geographical locations do you normally participate in this sport or avocation? (example: specific track or body of water, composition and shape of track, state or foreign country) _____

6. Do you or have you ever participated in any experimental forms of this sport or avocation? Yes No

If Yes, give full details: _____

7. How long have you been participating in this sport or avocation? _____

8. How many times did you participate in the past twelve (12) months? _____

9. How frequently do you expect to participate in the next twelve (12) months? _____

10. What is the greatest height/depth/speed you have obtained? _____

11. How many times have you attained this height/depth/speed? _____

12. What is the average height/depth/speed? _____

13. What is the average length of time you spend in each instance of participation in this activity? _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this sports, amusement, or avocation history.



Racing Questionnaire

Issued by American National Insurance Company
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]



Name _____ Birthdate _____ File # _____

1. Have you engaged in during the last 12 months, or do you contemplate engaging in the next 12 months, in any of the following form(s) of racing?

- Automobile Yes No
- Motorcycle Yes No
- Motorboat Yes No
- Hydroplane Yes No
- Other(s) Yes No

If Yes, specify: _____

If Yes, give details below:

Types of Racing*	1-2 Years Ago		Last 12 Months		Average Speed of Fastest Race	Fastest Speed Attained	Contemplated Next 12 Month	
	Number of Races	Total Miles Raced	Number of Races	Total Miles Raced			Number of Races	Total Miles

*Examples

- Automobile — midget, sports car, stock car, championship, drag, kart
- Motorcycle — hill climbing, cross country, circular track
- Motorboat — unmodified, modified, experimental
- Unlimited hydroplane — jet, other

2. Do you own a competitive vehicle(s)? _____ If Yes, give type(s): _____

3. Over what period of the year do you race? (example: month, six months, entire year) _____

4. How far do you travel to race? _____

5. Have you ever competed or do you contemplate competing outside the United States in the next 12 months? _____
If Yes, give details: _____

6. Over what type of track do you race? (example: oval, simulated road) _____

7. Do you race professionally or for cash prizes? _____

8. Additional remarks clarifying answers to above questions: _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this racing history.



Chest Pain Questionnaire

Issued by American National Insurance Company
[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]



Name _____ Birthdate _____ File # _____

1. Have you ever been diagnosed with or been treated by a member of the medical profession for: **YES** **NO** Please give details of all Yes answers - dates, durations, results, doctors' names and addresses.

- a) Chest pain? **YES** **NO**
- b) Palpitation? Skipping of heart? **YES** **NO**
- c) Shortness of breath? **YES** **NO**
- d) High blood pressure? **YES** **NO**

2. If pain was experienced in chest did it involve:
- a) Middle of chest? **YES** **NO**
 - b) Left side of chest? **YES** **NO**
 - c) Left shoulder, arm or hand? **YES** **NO**
 - d) Both shoulders or arms? **YES** **NO**
 - e) Sense of pressure or constriction? **YES** **NO**
 - f) Sweating **YES** **NO**
 - g) Was it associated with:
 - Exertion? Exercise? **YES** **NO**
 - Excitement? Strain? **YES** **NO**
 - h) Emergency medical care? **YES** **NO**

3. If Yes answers, please report:
- a) Approximate date of first attack? _____
 - b) Date of last attack? _____
 - c) How frequent: per day, week or month? _____
 - d) Duration of average attack? _____
 - e) Were you hospitalized? How long? _____
 - f) Were you confined at home? How long? _____
 - g) How long convalescent? _____
 - h) Date of return to work? Restrictions? _____
 - i) How many hours do you work daily? _____
 - j) What medicine are you now taking? _____

4. Please give names and addresses of all your attending doctors. _____

5. What diagnosis was made, by a member of the medical profession, concerning your chest pain or heart condition? _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this medical history.



Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates and Preferred Plus Rates

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

page 1 of 1

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



Name _____ Birthdate _____

1.) Have you ever used nicotine of any kind? Yes No

(Nicotine includes cigarettes, cigar, pipe, chewing tobacco, nicotine patches or other products containing nicotine.)

If yes, when did you last use nicotine? _____
Month/Year

2.) Family History:

PARENTS	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	SIBLINGS	#	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
FATHER				BROTHERS AND SISTERS-# LIVING				
MOTHER				# DECEASED				

Did (does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Yes No

If yes, at what age diagnosed? _____

Did (does) anyone in the immediate family have a history of internal cancer or melanoma? Yes No

If yes, at what age diagnosed? _____ Type and location _____

3.) Driving Record:

Any history of DUI/DWI or reckless driving in the last five years? Yes No

Any other moving violations in the last five years? Yes No

Drivers License Number: State _____ Number _____

4.) In the last 10 years has there been treatment and/or counseling for alcohol or drugs by a member of the medical profession?

Yes No

Fraud Warning

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Signature of Proposed Insured

Date

Signature of Agent

Date

SERFF Tracking Number: AMNA-127298041 State: Arkansas
 Filing Company: American National Insurance Company State Tracking Number: 49170
 Company Tracking Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES
 Project Name/Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES/ANICO MEDICAL STATEMENTS/QUESTIONNAIRES

Supporting Document Schedules

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

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: This is not a product filing.		
Comments:		

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

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: AR ANICO.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment:		

SERFF Tracking Number: AMNA-127298041 *State:* Arkansas
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TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single
Life
Product Name: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES
Project Name/Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES/ANICO MEDICAL STATEMENTS/QUESTIONNAIRES

AR MVM - Questionnaires.pdf



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>
AN-SME	Statements to Medical Examiner	51.2
Form 10394	Certificate Statement of Health	53.3
AN-MIL-AR	Military Status Questionnaire	66.5
AN-FOR-AR	Foreign Travel Questionnaire	57.9
AN-DIA-AR	Diabetic Questionnaire	61.2
AN-DIS-AR	Disabled Applicant Questionnaire	50.9
AN-EPI-AR	Epilepsy/Seizure Questionnaire	61.5
AN-SCU-AR	Scuba Diving Questionnaire	57.9
AN-RES-AR	Respiratory Questionnaire	62.1
AN-BLO-AR	Blood Pressure Questionnaire	60.3
AN-HBP-AR	High Blood Pressure Questionnaire	68.7
AN-DRU-AR	Drug Use Questionnaire	55.9
AN-ALC-AR	Alcohol Use Questionnaire	52.1
AN-CUP-AR	Check-up Questionnaire	50.7
AN-AVI-AR	Aviation Questionnaire	57.8
AN-MOT-AR	Motor Sports Questionnaire	66.5
AN-SPO-AR	Sports Amusement Questionnaire	50.7
AN-RAC-AR	Racing Questionnaire	62.1
AN-CPA-AR	Chest Pain Questionnaire	77.8
Form 4544-AR	Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates and Preferred Plus Rates	54.9

Rex D. Hemme
Senior Vice President & Actuary
American National Insurance Company
6/21/2012



Tobie Brink, Life Policy Analyst III
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June 29, 2011

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

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

AN-SME	Statements to Medical Examiner
Form 10394	Certificate Statement of Health
AN-MIL-AR	Military Status Questionnaire
AN-FOR-AR	Foreign Travel Questionnaire
AN-DIA-AR	Diabetic Questionnaire
AN-DIS-AR	Disabled Applicant Questionnaire
AN-EPI-AR	Epilepsy/Seizure Questionnaire
AN-SCU-AR	Scuba Diving Questionnaire
AN-RES-AR	Respiratory Questionnaire
AN-BLO-AR	Blood Pressure Questionnaire
AN-HBP-AR	High Blood Pressure Questionnaire
AN-DRU-AR	Drug Use Questionnaire
AN-ALC-AR	Alcohol Use Questionnaire
AN-CUP-AR	Check Up Questionnaire
AN-AVI-AR	Aviation Questionnaire
AN-MOT-AR	Motor Sports Questionnaire
AN-SPO-AR	Sports, Amusement or Avocation Questionnaire
AN-RAC-AR	Racing Questionnaire
AN-CPA-AR	Chest Pain Questionnaire
Form 4544-AR	Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates and Preferred Plus Rates

SERFF Tracking Number: AMNA- 127298041

Company Tracking Number: ANICO MEDICAL STATEMENTS/QUESTIONNAIRES

Dear Reviewer:

Please find attached the above referenced forms for your department's review and approval. These forms will be used with approved individual life insurance products.

AN-SME-AR - This form is the Statements to Medical Examiner form. This form will replace previously approved form 9928 1/88 approved on 2/3/88. 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.

10394-AR - This form is the Certificate Statement of Health. This is a new form and will not replace any previously approved form. The Authorization section of the application requires that the applicant be in the same health condition as described in the application when the policy is delivered in order for the policy to be effective. This form will be provided to the applicant at the time of policy delivery and will be required to be signed and returned before the policy becomes effective. A completed copy of the form will be provided to the Owner for attachment to the application/policy.

Medical Questionnaires - These forms will replace previously approved forms via SERFF tracking number AMNA-125968137 approved on 3/2/09. Within the application, there is medical history and other similar type questions used to assist us in determining the insurability and risk class of the applicant. For some of these questions, a 'yes' answer will prompt the use of a supplemental questionnaire in order to gather more information. In addition to a 'yes' answer, the underwriter can request the completion of a supplemental questionnaire at their discretion, usually based on findings in a report or medical examination on the applicant obtained during the underwriting process. When used, these questionnaires will be attached to and considered a part of the application, which is attached to and made a part of the policy.

These questionnaires will be used with all current and future approved life insurance applications, insurability, and reinstatement applications.

Form 4544-AR - This form is the Supplemental Questionnaire for Consideration of Standard Plus, Preferred Rates and Preferred Plus Rates. This is a new form and will not replace any previously approved form. It is used when there are more than two adults applying for coverage on one application to provide the family history of the additional adults. It is also used when requesting a change to preferred rates on a policy change.

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.

Sincerely,

Tobie Brink

Tobie Brink
Life Policy Analyst III



June 21, 2011

MEMORANDUM OF VARIABLE MATERIAL FOR:

- AN-SME
- Form 10394
- AN-MIL-AR
- AN-FOR-AR
- AN-DIA-AR
- AN-DIS-AR
- AN-EPI-AR
- AN-SCU-AR
- AN-RES-AR
- AN-BLO-AR
- AN-HBP-AR
- AN-DRU-AR
- AN-ALC-AR
- AN-CUP-AR
- AN-AVI-AR
- AN-MOT-AR
- AN-SPO-AR
- AN-RAC-AR
- AN-CPA-AR
- Form 4544-AR

This memorandum was prepared for use with the questionnaires listed above by 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
Mailing Office Address
Business (telephone number)
Business (fax number)

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.