

SERFF Tracking Number: AMNA-127388971 State: Arkansas  
Filing Company: American National Insurance Company State Tracking Number: 49708  
Company Tracking Number: IPIPELINE E-APP  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: iPipeline E-App  
Project Name/Number: /

## Filing at a Glance

Company: American National Insurance Company

Product Name: iPipeline E-App

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMNA-127388971 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num: 49708

For Informational Purposes

Co Tr Num: IPIPELINE E-APP

State Status: Filed-Closed

Reviewer(s): Linda Bird

Authors: Tyra Reed, Amber Adams, Disposition Date: 09/08/2011

Tobie Brink

Date Submitted: 09/02/2011

Disposition Status: Accepted For

Informational Purposes

Implementation Date:

Implementation Date Requested: 10/01/2011

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 08/25/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 09/08/2011

State Status Changed: 09/08/2011

Created By: Amber Adams

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Amber Adams

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:

Electronic Application Process for Form 10193

SERFF Tracking Number: AMNA - 127388971

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Dear Reviewer:

This is an update to the previously approved application listed above, approved on March 2, 2009, under SERFF tracking number AMNA-125968137 and state tracking number 41678. No changes have been made to the application form. However, we would like to utilize the application in an electronic form. The Agent will ask the applicant all the questions on the application and enter the applicant's answers into the computer. The questions will be identical to the ones in the currently approved application.

This application will be used with currently approved life insurance forms, including:

Whole Life  
Term Life  
Universal Life  
Indexed Universal Life  
Variable Universal Life

The authentication of the e-transaction is as follows:

American National Insurance Company will be collecting electronic signatures on life insurance forms via a process known as eSignature (Click Wrap). This process enables individual signers to review forms and attach electronic signatures via email, eliminating the need for wet signatures on applications.

After the application has been locked, the processes to define signature parties, gather signatures from those parties, and ultimately submit a completed application package to American National Insurance Company is defined below.

Upon initially reaching the end of the application process, the agent is presented with a dynamic screen called "Validate and Lock" that allows them to do one of two things, return to areas of the application that are not in Good Order, or lock the application if it's in Good Order.

The eSignature instructions screen displays the signing parties' names. It also requires the agent to enter the last 4 digits of their Social Security Number, which they will need, to log in when it is time to affix their electronic signature to the application. The agent is also required to enter the Email address for notifications and confirm the same. After the agent has initiated the eSignature process, the signature party will receive an email with a link to view the applicable documents. The signing party will need to enter the last four digits of their ssn to access the documents they are to review and sign.

Once the agent has locked an application and chosen to utilize the electronic signature process, the agent goes through

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a series of steps to identify the particular email that each signing party will use and then send that email to the party.

The URL contained in this email will last for seven calendar days until expiration. In addition, the URL will expire if any of the following events happen:

Successful completion of the eSignature process  
Any signer completely declines the eSignature process  
Regeneration of a new email to the same party  
Completion of three unsuccessful login attempts

If changes are needed to the application once the signature process has begun, all signatures are voided and the signature process must begin again.

After all signing parties (Insured and/or Owner) complete the signature process successfully, an email is sent to the agent informing them as such, and that it is time for the agent to affix their signature to the forms. This email contains the URL that the agent will click on in order to start their eSignature process.

The agent's signature process begins as he/she receives an email indicating all other required signatures have been obtained. The agent's signature process cannot begin until all non-agents signatures have been applied; therefore, if a decline or expiration takes place for an insured or owner, the agent could not begin the eSignature process. After the agent reviews the Terms of Use and Application, the producer "Apply eSignature" screen is displayed. This screen is functionally similar to the Primary Insured/Owner version, with different text. The Agent will enter Signed at City and click "Apply eSignature" button. After clicking "Apply eSignature" the screen will refresh and display a link to "Print Signed Application" and a button to "Submit to ANICO". If one of the signing parties did not consent to the eSignature method, the agent could print the application and supplemental forms for a wet signature.

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

- Payment of any required filing fee
- A "John Doe" version of an electronic application
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

## Company and Contact

### Filing Contact Information

Amber Adams, Product Development Attorney amber.adams@anico.com  
One Moody Plaza 409-763-1112 [Phone] 5479 [Ext]  
14th Floor 409-766-6933 [FAX]  
Galveston, TX 77590

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**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

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	\$100.00	09/02/2011	51243746

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Linda Bird Informational Purposes		09/08/2011	09/08/2011

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## Disposition

Disposition Date: 09/08/2011

Implementation Date:

Status: Accepted For Informational Purposes

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		Yes
Supporting Document	John Doe Application		Yes
Supporting Document	Cover Letter		Yes

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## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

AR - CERTIFICATION OF COMPLIANCE.pdf

AR - READABILITY.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Application

**Comments:**

Approved Application

**Attachment:**

Form 10193-AR.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** John Doe Application

**Comments:**

**Attachment:**

AR - John Doe App.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Cover Letter

**Comments:**

**Attachment:**

AR.pdf



# American National Insurance Company

## ARKANSAS

### CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19

Rule & Regulation 49 ACA 23-79-138 and

Bulletin 11-88 ACA 23-80-206 (Flesch Certification, minimum of 40) – Form 10193-AR and supplemental documents listed below achieves a score of at least 50.0

Form 10193-AR - Application for Life Insurance

- 3517- AR – Declaration of Insurability – application supplement
- 10228 – Additional Beneficiary – application supplement
- 4643 – Drug Use Questionnaire – underwriting questionnaire
- 4644 – Alcohol Use Questionnaire – underwriting questionnaire
- 4687 – Respiratory Questionnaire – underwriting questionnaire
- 4688 – Epilepsy/Seizure Questionnaire – underwriting questionnaire
- 4689 – Disabled Applicant Questionnaire – underwriting questionnaire
- 4690 – Diabetic Questionnaire – underwriting questionnaire
- 4691 – Check-Up Questionnaire – underwriting questionnaire
- 8313 – Aviation Questionnaire – underwriting questionnaire
- 8313-A – Skin and Scuba Diving Questionnaire – underwriting questionnaire
- 8313-B – Motor Sports Questionnaire – underwriting questionnaire
- 8313-C – Sports, Amusement or Avocation Questionnaire – underwriting questionnaire
- 8313-D – Racing Questionnaire – underwriting questionnaire
- 9264 – Foreign Travel Questionnaire – underwriting questionnaire
- 10065 – Chest Pain Questionnaire – underwriting questionnaire
- 10100 – Blood Pressure Questionnaire – underwriting questionnaire

Rex D. Hemme Vice President &

Actuary American National Insurance

Company

tracey.johnfroe@anico.com Phone:  
(409) 763-4661 x5438 Fax: (409) 766-6933



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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>
Form 10139-AR	Application for Life Insurance	50

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Rex D. Hemme

Vice President & Actuary

American National Insurance Company



# Application for Life Insurance

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7999



## 1. PRIMARY PROPOSED INSURED

a. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ b. Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

c. Date of birth: Month/Day/Year \_\_\_\_\_ d. Age last birthday \_\_\_\_\_ e. Height \_\_\_\_\_ f. Weight \_\_\_\_\_ g. Social Security/Tax ID number \_\_\_\_\_

h. Gender  Male  Female i. Marital status:  Married  Separated  Single  Widowed  Divorced

j. Have you ever used tobacco or nicotine in any form? .....  Yes  No  
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | \_\_\_\_\_

k. Residence address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

l. Years at this residence \_\_\_\_\_ m. Personal telephone \_\_\_\_\_ n. Annual Income \_\_\_\_\_ Net worth \_\_\_\_\_  
| (\_\_\_\_\_) \_\_\_\_\_ | \$ \_\_\_\_\_ | \$ \_\_\_\_\_

o. Type of business \_\_\_\_\_ Employer name \_\_\_\_\_ p. Business telephone \_\_\_\_\_  
| \_\_\_\_\_ | (\_\_\_\_\_) \_\_\_\_\_

q. Occupation/Job title \_\_\_\_\_ Job duties (Be specific.) \_\_\_\_\_ r. Date of employment: Month/Year \_\_\_\_\_

s. Business address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

t. U.S. Citizen:  Yes  No If No, type of Visa \_\_\_\_\_ Expiration Date \_\_\_\_\_

## 2. ADDITIONAL PROPOSED INSURED

a. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ b. Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

c. Date of birth: Month/Day/Year \_\_\_\_\_ d. Age last birthday \_\_\_\_\_ e. Height \_\_\_\_\_ f. Weight \_\_\_\_\_ g. Social Security/Tax ID number \_\_\_\_\_

h. Gender  Male  Female i. Marital status:  Married  Separated  Single  Widowed  Divorced

j. Have you ever used tobacco or nicotine in any form? .....  Yes  No  
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | \_\_\_\_\_

k. Residence address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

l. Years at this residence \_\_\_\_\_ m. Personal telephone \_\_\_\_\_ n. Annual Income \_\_\_\_\_ Net worth \_\_\_\_\_  
| (\_\_\_\_\_) \_\_\_\_\_ | \$ \_\_\_\_\_ | \$ \_\_\_\_\_

o. Type of business \_\_\_\_\_ Employer name \_\_\_\_\_ p. Business telephone \_\_\_\_\_ q. Relationship to primary proposed insured \_\_\_\_\_

r. Occupation/Job title \_\_\_\_\_ Job duties (Be specific.) \_\_\_\_\_ s. Date of employment: Month/Year \_\_\_\_\_

t. Business address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

u. U.S. Citizen:  Yes  No If No, type of Visa \_\_\_\_\_ Expiration Date \_\_\_\_\_

## 3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship to primary proposed insured \_\_\_\_\_

c. Gender  Male  Female d. Date of birth: Month/Day/Year \_\_\_\_\_ e. Age last birthday \_\_\_\_\_ f. Social Security/Tax ID number \_\_\_\_\_ g. If Trust, date created \_\_\_\_\_

h. Mailing address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

i. Contingent owner (If any): Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ j. Relationship to primary proposed insured \_\_\_\_\_



**4. SECONDARY OR ALTERNATE ADDRESSEE (if applicable)**

Name | \_\_\_\_\_ Address: Number/Street | \_\_\_\_\_  
City | \_\_\_\_\_ State | \_\_\_\_\_ ZIP | \_\_\_\_\_

**5. CHILDREN PROPOSED FOR INSURANCE (COMPLETE FOR CHILDREN TERM RIDER)**

Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Age	Ht./Wt.	Gender: Soc. Sec./Tax ID# M/F
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

- a. Has the name of any child age 18 or younger been omitted?  Yes (Explain.) | \_\_\_\_\_  No
- b. Is any child NOT living at the same address as the proposed insured?  Yes (Explain.) | \_\_\_\_\_  No

**6. BENEFICIARY FOR PRIMARY PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)**

Primary: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender: Soc. Sec./Tax ID# M/F	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Contingent: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender: Soc. Sec./Tax ID# M/F	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options:  Yes  No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

**7. BENEFICIARY FOR ADDITIONAL PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)**

Primary: Last name	First name	M.I.	Relationship to additional proposed insured	Date of Birth: Mo./Day/Yr.	Gender: Soc. Sec./Tax ID# M/F	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options:  Yes  No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

**8. PRODUCT INFORMATION**

a. Plan of insurance (Specify number of years if Term) \_\_\_\_\_ b. Amount of insurance \_\_\_\_\_

c. Premium amount \$ \_\_\_\_\_ Mode:  Annual  Semiannual  Quarterly  Monthly  Single premium

d. If all proposed insured(s) are acceptable risks on a nonrated basis, but the premium quoted will not purchase the face amount requested:

- Do NOT change premium. Change face amount.
- Do NOT change face amount. Change premium.

Was automatic premium loan elected?  Yes  No (In Rhode Island, automatic premium loan is required, unless otherwise elected.)

**If Participating Whole Life**

e. Dividend option:  Cash  Premium reduction  Paid-up additions  Accumulate at interest

**If Universal Life (including Indexed Universal Life and Variable Universal Life)**

f. Death benefits options (Elect one - If no option is selected, Option "A" will be issued)  Option A  Option B  Option C

**If Indexed Universal Life**

g. Initial Allocation of Net Premiums (Allocation must be designated in percentages and must total 100%)

\_\_\_\_\_ % Fixed Interest Crediting Option \_\_\_\_\_ % Indexed Interest Crediting Option

**If Variable Universal Life**

h. Guaranteed Coverage Period: (Elect one.)  10-year  25-year  Other \_\_\_\_\_

Amount paid with application: \$ \_\_\_\_\_ (Check must be payable to American National Insurance Company.)



9. RIDERS/BENEFITS (Complete insurability application, if necessary.)

a. Optional benefits/riders:

- Optional benefits/riders including Premium waiver, Waiver of stipulated premium, Accidental death, Children term, Spouse term, Guaranteed increase option, Additional insurance option, Return of Premium Rider, Paid Up Additions Rider, Premium payor, Coverage continuation rider, Other insured rider, Level term.

Other: Type of Rider, Name of insured, Amount of insurance

Beneficiary for Other Insured Rider Coverage (Unless specified, all beneficiaries in the same class share equally.)

Table with columns: Primary: Last name, First name, M.I., Relationship to other insured rider, Date of Birth: Mo./Day/Yr., Gender: M/F, Soc. Sec./Tax ID#, Date of trust: Mo./Day/Yr., % payable

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

10. INSURANCE AND REPLACEMENTS

- Do you have existing life insurance or annuity coverage? Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company? Total Insurance/Annuities in force on Proposed Insured(s):

Table with columns: Full Name of Company, Policy No., Issue Date, Insured's Name, Plan, Amount, See "10b"

Accidental Death \$ Company

11. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents: Is parent living (Y/N), Age if living, Age at death, Cause of death. Father, Mother

Siblings: Number of living, Number deceased, Age at death, Cause of death

- Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?

12. ADDITIONAL PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents: Is parent living (Y/N), Age if living, Age at death, Cause of death. Father, Mother

Siblings: Number of living, Number deceased, Age at death, Cause of death

- Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?



**13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC**

a. Family physician, specialist or clinic of **proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
Address: Number/Street	City	State ZIP	Provider telephone number

b. Family physician, specialist or clinic of **additional proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
Address: Number/Street	City	State ZIP	Provider telephone number

**14. MEDICAL HISTORY QUESTIONS—LIFETIME**

(For questions "14.a." through "16.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 17.)

a. Is any proposed insured taking any medication(s)?  Yes  No (If "Yes," list medications and prescribed dosages).

**HAS ANY PROPOSED INSURED EVER ...**

- b. had a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels?.....  Yes  No
- c. had cancer, a tumor or abnormal growth of any kind? .....  Yes  No
- d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? .....  Yes  No

**15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS**

**HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS ...**

- a. had seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system? ...  Yes  No
- b. had asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system?.....  Yes  No
- c. had any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis? .....  Yes  No
- d. had any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? .....  Yes  No
- e. had diabetes or any disease of the thyroid or other gland? .....  Yes  No
- f. had arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin? .....  Yes  No
- g. had treatment or counseling for use of alcohol or alcoholism? .....  Yes  No
- h. had treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? .....  Yes  No
- i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed? .....  Yes  No
- j. If any proposed insured(s) is less than one year old, give birth weight: | \_\_\_\_ lb. | \_\_\_\_ oz. Was birth premature? .....  Yes  No

**16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS**

**HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS ...**

- a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? .....  Yes  No
- b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test? .....  Yes  No
- c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed?  Yes  No



**17. MEDICAL HISTORY EXPLANATIONS**

(Give full details below of all "Yes" answers to questions "14.a." through "16.c.")

Question	Person	Reason, condition, disease, injury, etc.		Date
_____   _____	_____   _____	_____   _____		_____   _____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____   _____	_____   _____	_____   _____	_____   _____	_____   _____

  

Question	Person	Reason, condition, disease, injury, etc.		Date
_____   _____	_____   _____	_____   _____		_____   _____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____   _____	_____   _____	_____   _____	_____   _____	_____   _____

  

Question	Person	Reason, condition, disease, injury, etc.		Date
_____   _____	_____   _____	_____   _____		_____   _____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____   _____	_____   _____	_____   _____	_____   _____	_____   _____

  

Question	Person	Reason, condition, disease, injury, etc.		Date
_____   _____	_____   _____	_____   _____		_____   _____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____   _____	_____   _____	_____   _____	_____   _____	_____   _____

**18. INSURANCE HISTORY AND NON-MEDICAL HAZARDS**

- a. Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate?  Yes  No (If "Yes," give details.)

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- b. Has any proposed insured in the last six (6) months, applied for — or is any proposed insured contemplating applying for — other insurance with this, or any other, company?  Yes  No (If "Yes," state how much and to whom.)

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- c. Has any proposed insured, in the past five (5) years, made — or is any proposed insured contemplating making — flights as a pilot, student pilot, crew member, or observer?  Yes  No (If "Yes," complete and submit the appropriate questionnaire.)
- d. Has any proposed insured, in the past five (5) years, engaged in — or does any proposed insured intend to engage in — any hazardous avocation or sport, such as SCUBA diving, parachuting, hang-gliding, vehicle racing, or other hazardous avocation(s)?  Yes  No (If "Yes," complete and submit the appropriate questionnaire.)
- e. Has any proposed insured, in the past five (5) years, been convicted of a felony?  Yes  No (If "Yes," give details including county and state of conviction.)

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- f. Is any proposed insured currently on parole or probation?  Yes  No (if "yes", give details.)

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- g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?.....  Yes  No
- h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks?.....  Yes  No  
(If "Yes," complete and submit the Foreign Travel Questionnaire.)

**Primary Proposed Insured**

- i. Driver's license number: | \_\_\_\_\_ State: | \_\_\_\_\_
- j. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?.....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_
- k. Do you have any other moving violations in the last five (5) years? .....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_

**Additional Proposed Insured**

- l. Driver's license number: | \_\_\_\_\_ State: | \_\_\_\_\_
- m. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?.....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_
- n. Do you have any other moving violations in the last five (5) years? .....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_



**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

**APPLICATION DECLARATIONS AND AGREEMENTS**

Each of the undersigned declares for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true. They also agree that: (1) these answers as written: (i) were given to induce the company to issue a policy; and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial number as this application, no policy will be effective until it is: (i) issued; (ii) delivered to the applicant; and (iii) the full first premium paid, all during the lifetime and good health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be effective unless agreed to by the applicant in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and (5) only the president or a vice president or secretary of the company has the authority to waive any of the company rights or requirements or to waive or alter any of the provisions of: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

**FRAUD STATEMENT**

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.

**FCRA / MIB ACKNOWLEDGEMENT**

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

**APPLICATION SIGNATURES**

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

**For Indexed Universal Life:**

**I understand that I am applying for an indexed universal life policy and that while the value of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investment.**

**For Variable Universal Life:**

**I understand that I am applying for a Variable Universal Life Policy. The accumulation value may increase or decrease depending on investment returns and the death benefit may be variable or fixed depending on the death benefit option selected.**

Date: Month/Day/Year	Signed at: City	State	Country
_____	_____	_____	_____

Witnessed by: Signature of licensed agent	Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)
<b>X</b> _____	<b>X</b> _____

Print agent's name	Signature of additional person(s) proposed for insurance
_____	<b>X</b> _____

Agent's state license number	Signature of additional person(s) proposed for insurance
_____	<b>X</b> _____

Agent's company personal code	Signature of owner if other than proposed insured
_____	<b>X</b> _____



19. SOLICITING AGENT'S REPORT: THESE QUESTIONS MUST BE ANSWERED IN EVERY CASE

- a. How long have you personally known the proposed insured? Years | \_\_\_\_\_ Months | \_\_\_\_\_
b. By whom will premiums be paid? [ ] Owner [ ] Applicant [ ] Other (If "Other," explain.) | \_\_\_\_\_
c. What is your estimate of the premium payor's annual income? \$ \_\_\_\_\_ and worth? \$ \_\_\_\_\_
d. If the proposed insured is a child, how much insurance does the Parent/Premium Payor have in force on his/her own life? \$ \_\_\_\_\_
e. Give any other surname(s) used by any proposed insured in the last five years. | \_\_\_\_\_
f. If beneficiary is not a relative, explain insurable interest. | \_\_\_\_\_
g. Did you see each person proposed for insurance when the application was completed? ..... [ ] Yes [ ] No
h. Was beneficiary present during the completion of the application? ..... [ ] Yes [ ] No
i. As agent, do you certify that, on the date of this application, you asked the proposed insured each question in the application, recorded the answers given you, witnessed such person's signature, and collected the initial premium shown in the application? ..... [ ] Yes [ ] No
j. Do you have knowledge of any health history of any proposed insured not listed on this application? ..... [ ] Yes [ ] No
k. As agent, did you determine this applicant's insurable objective and/or financial need? ..... [ ] Yes [ ] No
l. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... [ ] Yes [ ] No
m. As agent, have you complied with state replacement regulations? ..... [ ] Yes [ ] No
n. As agent, did you include individualized sales proposals in your presentations? ..... [ ] Yes [ ] No
(If the primary proposed insured is replacing an existing plan(s) with this policy, the comparative information forms for each policy to be replaced, and copies of all sales material, MUST be included with this application sent to the home office.)
o. If a child, are there any other minor age siblings in the home? ..... [ ] Yes [ ] No
If yes, do they have the same amount of coverage in force or applied for? [ ] Yes [ ] No If "no", explain \_\_\_\_\_

Dated at: City \_\_\_\_\_ Month/Day/Year \_\_\_\_\_
Corporation name \_\_\_\_\_ Tax ID \_\_\_\_\_ Social Security number \_\_\_\_\_
Branch office number and PSO code \_\_\_\_\_ Agent personal code or number \_\_\_\_\_ CSSD District Code 2 \_\_\_\_\_ Agency # \_\_\_\_\_
Licensed agent's signature \_\_\_\_\_ Agent e-mail \_\_\_\_\_ Telephone number \_\_\_\_\_
X \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

If prior quote was reviewed, please provide quote number: | \_\_\_\_\_
Additional policy plan and amount
\_\_\_\_\_ \$ \_\_\_\_\_
Alternate policy plan and amount
\_\_\_\_\_ \$ \_\_\_\_\_
Are commissions to be split? [ ] Yes [ ] No (If "Yes," and split 50/50, list both agents' names and personal code number. If NOT, complete and submit Form 6151.)
Agent name \_\_\_\_\_ Personal code or number \_\_\_\_\_ Agent name \_\_\_\_\_ Personal code or number \_\_\_\_\_
Special Instructions: | \_\_\_\_\_

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:
Oral fluid test collected by agent [ ] Yes [ ] No Date collected? | \_\_\_\_\_ [ ] Lab ticket attached or affix barcode here: \_\_\_\_\_
Inspection ordered [ ] Yes [ ] No (If "Yes," give name of inspection service used.)
\_\_\_\_\_
[ ] Exam by physician, full blood, HOS [ ] EKG [ ] X-ray [ ] Paramed, full blood, HOS [ ] Full blood, physical measurements, HOS
[ ] Paramed, HOS | \_\_\_\_\_ [ ] Other | \_\_\_\_\_
Name of approved paramed company? | \_\_\_\_\_
Were medical records (APS) ordered by producer? [ ] Yes [ ] No (If "Yes," give physician/clinic name)
\_\_\_\_\_
Did you pay for the attending physician's statement? ..... [ ] Yes [ ] No
(If "Yes," enter check # | \_\_\_\_\_ and amount \$ \_\_\_\_\_)
Has the application been reviewed for omissions and errors? ..... [ ] Yes [ ] No
If "yes", by (name) \_\_\_\_\_



**22. NUMBER OF APPLICATIONS**

Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National? .....  Yes  No  
(If "Yes," give the serial number on the other application(s).)

**23. NOTES TO UNDERWRITER**

**24. BILLING DATA**

- a. Mode:  Annual  Semiannual  Quarterly  Monthly  Single premium
- b. Method:  Direct: (Fill in name and address where premium notices are to be sent, ONLY IF OTHER than those of primary proposed insured.)

Name \_\_\_\_\_  
 Number/Street \_\_\_\_\_ City \_\_\_\_\_  
 State ZIP \_\_\_\_\_ Country \_\_\_\_\_

Electronic fund transfer (EFT): (Complete "Electronic Fund Transfer" section 25 and attach a void check.)

MDO

Salary deduction: Name \_\_\_\_\_ Number \_\_\_\_\_  
 Biweekly Amount | \_\_\_\_\_

Government allotment: Payee name

- A. Copy of certified allotment attached to application
- B. Certified copy of Form 902 completed in lieu of allotment copy
- C. Cash with application — No allotment copy
- D. C.O.D. — Defer issue until allotment begins.

Rank | \_\_\_\_\_ Branch | \_\_\_\_\_ Social Security number | \_\_\_\_\_

Special dating instructions: Issue age | \_\_\_\_\_ Issue date | \_\_\_\_\_

**25. ELECTRONIC FUND TRANSFER (EFT) INFORMATION: ATTACH "VOID" SPECIMEN OF CHECK**

Name of premium payor who will pay premium \_\_\_\_\_ Social Security number \_\_\_\_\_

Name(s) of insured(s) \_\_\_\_\_

Account number:  Checking  Savings \_\_\_\_\_ Specify desired date for draft against account \_\_\_\_\_

Bank name \_\_\_\_\_ Branch name \_\_\_\_\_ Bank transit number \_\_\_\_\_

Bank address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State ZIP \_\_\_\_\_

The undersigned requests the above-named bank to honor debit entries, either by electronic or paper means, to my account and payable to American National Insurance Company of Galveston, Texas. I agree that there will be no liability, on your part, for any reason whatsoever, for payment or failure to pay any such debit item. If, at any time, I do not have on deposit, in said bank, available funds sufficient to pay such debits, the pre-authorized payment privilege shall be automatically discontinued. Premiums then due or becoming due thereafter must be paid in accordance with one of the other methods of premium payment available to the policyowner. It is understood and agreed that all debit entries are accepted by the Company subject to their being honored upon presentation.

Date: Month/Day/Year \_\_\_\_\_

Signature of premium payer \_\_\_\_\_  
**X** \_\_\_\_\_

Agent \_\_\_\_\_  
**X** \_\_\_\_\_



**CONDITIONAL RECEIPT**

**THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.**

**AMERICAN NATIONAL INSURANCE COMPANY  
One Moody Plaza, Galveston, Texas 77550-7999**

**PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL INSURANCE COMPANY.  
DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

I have received \$ \_\_\_\_\_ in connection with an application for life insurance bearing the same serial number as this receipt. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

- (1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
- (2) All medical examinations and tests required under the company's initial application requirements must be completed and the reports of those medical examinations and tests must be received at the company's home office within 45 days after the date of this receipt;
- (3) On the effective date, as defined below, all persons proposed for insurance must be in good health and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
- (4) There is no material misrepresentation in the application.

**MAXIMUM AMOUNT LIMITATION:** At no time and in no event shall the total liability of the company under this receipt and all other receipts providing conditional insurance coverage with the company on the lives of all the persons proposed for insurance exceed \$500,000.

**EFFECTIVE DATE MEANS THE LATEST OF:** (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

**REFUND OF PAYMENT:** If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the company's liability is limited to a refund of the amount paid. Only the president, a vice president or secretary of the company has the authority to waive any of the company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

Date: Month/Day/Year                      Signed at: City    State      Country

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

Signature of licensed agent

**X** \_\_\_\_\_

I have read this conditional receipt. It has been explained to me by the agent.

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

**X** \_\_\_\_\_

Signature of Owner

**X** \_\_\_\_\_



**AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED.**

**AMERICAN NATIONAL INSURANCE COMPANY**  
**One Moody Plaza, Galveston, Texas 77550-7999**

Thank you for considering American National Insurance Company as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

**Medical Information Bureau (MIB) Pre-notification** — Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the bureau's file, you may contact the bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the bureau's information office is: Medical Information Bureau, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, website address [www.mib.com](http://www.mib.com), telephone number (617) 426-3660. The American National Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**Fair Credit Reporting Act Pre-notification** — Federal and state laws require 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 the proper identification, you may inspect, or, for the appropriate fee, 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 your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of 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.



# Application for Life Insurance

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



## 1. PRIMARY PROPOSED INSURED

a. Last name DOE First name JOHN M.I. X b. Birthplace: City ANYTOWN State AR Country USA

c. Date of birth: Month/Day/Year 01/01/1965 d. Age last birthday 46 e. Height 5'9" f. Weight 175 g. Social Security/Tax ID number 999-99-9999

h. Gender  Male  Female i. Marital status:  Married  Separated  Single  Widowed  Divorced

j. Have you ever used tobacco or nicotine in any form? .....  Yes  No  
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | \_\_\_\_\_

k. Residence address: Number/Street 123 MAIN STREET City ANYTOWN State AR ZIP 72000

l. Years at this residence 15 m. Personal telephone (999) 999-9999 n. Annual Income \$ 200,000 Net worth \$ 400,000

o. Type of business LEGAL Employer name SELF p. Business telephone (999) 888-8888

q. Occupation/Job title ATTORNEY Job duties (Be specific.) FAMILY, PROBATE AND CIVIL LAW r. Date of employment: Month/Year 05/05/1985

s. Business address: Number/Street 987 BROAD STREET City ANYTOWN State AR ZIP 72000

t. U.S. Citizen:  Yes  No If No, type of Visa \_\_\_\_\_ Expiration Date \_\_\_\_\_

## 2. ADDITIONAL PROPOSED INSURED

a. Last name DOE First name JANE M.I. X b. Birthplace: City ANYTOWN State AR Country USA

c. Date of birth: Month/Day/Year 08/08/1968 d. Age last birthday 43 e. Height 5'6" f. Weight 136 g. Social Security/Tax ID number 888-88-8888

h. Gender  Male  Female i. Marital status:  Married  Separated  Single  Widowed  Divorced

j. Have you ever used tobacco or nicotine in any form? .....  Yes  No  
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | \_\_\_\_\_

k. Residence address: Number/Street 123 MAIN STREET City ANYTOWN State AR ZIP 72000

l. Years at this residence 15 m. Personal telephone (999) 999-9999 n. Annual Income \$ 135,000 Net worth \$ 250,000

o. Type of business MEDICAL Employer name GENERAL HOSPITAL p. Business telephone (999) 777-7777 q. Relationship to primary proposed insured SPOUSE

r. Occupation/Job title SURGICAL RN Job duties (Be specific.) ASST IN SURGERY s. Date of employment: Month/Year 06/06/1993

t. Business address: Number/Street 333 MEDICAL CENTER BLVD City ANYTOWN State AR ZIP 72000

u. U.S. Citizen:  Yes  No If No, type of Visa \_\_\_\_\_ Expiration Date \_\_\_\_\_

## 3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ b. Relationship to primary proposed insured \_\_\_\_\_

c. Gender  Male  Female d. Date of birth: Month/Day/Year \_\_\_\_\_ e. Age last birthday \_\_\_\_\_ f. Social Security/Tax ID number \_\_\_\_\_ g. If Trust, date created \_\_\_\_\_

h. Mailing address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

i. Contingent owner (If any): Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ j. Relationship to primary proposed insured \_\_\_\_\_



**4. SECONDARY OR ALTERNATE ADDRESSEE (if applicable)**

Name | \_\_\_\_\_ Address: Number/Street | \_\_\_\_\_  
City | \_\_\_\_\_ State | \_\_\_\_\_ ZIP | \_\_\_\_\_

**5. CHILDREN PROPOSED FOR INSURANCE (COMPLETE FOR CHILDREN TERM RIDER)**

Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Age	Ht./Wt.	Gender: Soc. Sec./Tax ID# M/F
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

- a. Has the name of any child age 18 or younger been omitted?  Yes (Explain.) | \_\_\_\_\_  No
- b. Is any child NOT living at the same address as the proposed insured?  Yes (Explain.) | \_\_\_\_\_  No

**6. BENEFICIARY FOR PRIMARY PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)**

Primary: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender: Soc. Sec./Tax ID# M/F	Date of trust: Mo./Day/Yr.	% payable
DOE	JENNIFER		DAUGHTER	05/05/1988	F	555-55-5555	
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Contingent: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender: Soc. Sec./Tax ID# M/F	Date of trust: Mo./Day/Yr.	% payable
DOE	JILL		SISTER	04/04/1962	F	444-44-4444	
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options:  Yes  No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

**7. BENEFICIARY FOR ADDITIONAL PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)**

Primary: Last name	First name	M.I.	Relationship to additional proposed insured	Date of Birth: Mo./Day/Yr.	Gender: Soc. Sec./Tax ID# M/F	Date of trust: Mo./Day/Yr.	% payable
DOE	JENNIFER		DAUGHTER	05/05/1988	F	555-55-5555	
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options:  Yes  No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

**8. PRODUCT INFORMATION**

a. Plan of insurance (Specify number of years if Term) **EXECUTIVE UL** b. Amount of insurance **250,001**

c. Premium amount \$ **488.85** Mode:  Annual  Semiannual  Quarterly  Monthly  Single premium

d. If all proposed insured(s) are acceptable risks on a nonrated basis, but the premium quoted will not purchase the face amount requested:  
 Do NOT change premium. Change face amount.  Do NOT change face amount. Change premium.

Was automatic premium loan elected?  Yes  No (In Rhode Island, automatic premium loan is required, unless otherwise elected.)

**If Participating Whole Life**

e. Dividend option:  Cash  Premium reduction  Paid-up additions  Accumulate at interest

**If Universal Life (including Indexed Universal Life and Variable Universal Life)**

f. Death benefits options (Elect one - If no option is selected, Option "A" will be issued)  Option A  Option B  Option C

**If Indexed Universal Life**

g. Initial Allocation of Net Premiums (Allocation must be designated in percentages and must total 100%)

\_\_\_\_\_ % Fixed Interest Crediting Option \_\_\_\_\_ % Indexed Interest Crediting Option

**If Variable Universal Life**

h. Guaranteed Coverage Period: (Elect one.)  10-year  25-year  Other \_\_\_\_\_

Amount paid with application: \$ \_\_\_\_\_ (Check must be payable to American National Insurance Company.)



9. RIDERS/BENEFITS (Complete insurability application, if necessary.)

a. Optional benefits/riders:

- Checkboxes for Premium waiver, Return of Premium Rider, Waiver of stipulated premium, Paid Up Additions Rider, Accidental death, Premium for PUA, Children term, Premium payor, Spouse term, Coverage continuation rider, Guaranteed increase option, Other insured rider, Additional insurance option, Level term.

Beneficiary for Other Insured Rider Coverage

(Unless specified, all beneficiaries in the same class share equally.)

Table with columns: Primary: Last name, First name, M.I., Relationship to other insured rider, Date of Birth: Mo./Day/Yr., Gender: M/F, Soc. Sec./Tax ID#, Date of trust: Mo./Day/Yr., % payable.

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

10. INSURANCE AND REPLACEMENTS

- a. Do you have existing life insurance or annuity coverage?
b. Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company?
c. Total Insurance/Annuities in force on Proposed Insured(s): If none in force indicate "NONE".

Table with columns: Full Name of Company, Policy No., Issue Date, Insured's Name, Plan, Amount, See "10b"

Accidental Death \$ Company

11. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents: Is parent living (Y/N), Age if living, Age at death, Cause of death. Rows for Father (DOE, MARTIN, 78) and Mother (DOE, MARY, 76).

Siblings: Number of living, Number deceased, Age at death, Cause of death. Row with 1 living, 0 deceased.

- a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident?
b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?

12. ADDITIONAL PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents: Is parent living (Y/N), Age if living, Age at death, Cause of death. Rows for Father (SMITH, FRANK, 70) and Mother (SMITH, FRANCINE, 68).

Siblings: Number of living, Number deceased, Age at death, Cause of death. Row with 2 living, 0 deceased.

- a. Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident?
b. Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?



**13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC**

a. Family physician, specialist or clinic of **proposed insured:**

Provider name: MARCUS WELBY Date last visited: 04/01/2009 Reason for visit: BRONCHITIS HMO patient ID number: \_\_\_\_\_  
Address: Number/Street: 444 MEDICAL CENTER BLVD City: ANYTOWN State: AR ZIP: 72000 Provider telephone number: (999) 111-1111

b. Family physician, specialist or clinic of **additional proposed insured:**

Provider name: MARCUS WELBY Date last visited: 0/25/2010 Reason for visit: RASH HMO patient ID number: \_\_\_\_\_  
Address: Number/Street: 444 MEDICAL CENTER BLVD City: ANYTOWN State: AR ZIP: 72000 Provider telephone number: (999) 111-1111

**14. MEDICAL HISTORY QUESTIONS—LIFETIME**

(For questions "14.a." through "16.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 17.)

a. Is any proposed insured taking any medication(s)?  Yes  No (If "Yes," list medications and prescribed dosages).

\_\_\_\_\_

**HAS ANY PROPOSED INSURED EVER ...**

- b. had a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels?.....  Yes  No
- c. had cancer, a tumor or abnormal growth of any kind? .....  Yes  No
- d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? .....  Yes  No

**15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS**

**HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS ...**

- a. had seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system?...  Yes  No
- b. had asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system?.....  Yes  No
- c. had any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis? .....  Yes  No
- d. had any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? .....  Yes  No
- e. had diabetes or any disease of the thyroid or other gland? .....  Yes  No
- f. had arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin? .....  Yes  No
- g. had treatment or counseling for use of alcohol or alcoholism? .....  Yes  No
- h. had treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? .....  Yes  No
- i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed? .....  Yes  No
- j. If any proposed insured(s) is less than one year old, give birth weight: | \_\_\_\_\_ lb. | \_\_\_\_\_ oz. Was birth premature? .....  Yes  No

**16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS**

**HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS ...**

- a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? .....  Yes  No
- b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test? .....  Yes  No
- c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed?  Yes  No



**17. MEDICAL HISTORY EXPLANATIONS**

(Give full details below of all "Yes" answers to questions "14.a." through "16.c.")

Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____
Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____
Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____
Question	Person	Reason, condition, disease, injury, etc.		Date
_____	_____	_____		_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City	State
_____	_____	_____	_____	_____

**18. INSURANCE HISTORY AND NON-MEDICAL HAZARDS**

- a. Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate?  Yes  No (If "Yes," give details.)

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- b. Has any proposed insured in the last six (6) months, applied for — or is any proposed insured contemplating applying for — other insurance with this, or any other, company?  Yes  No (If "Yes," state how much and to whom.)

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- c. Has any proposed insured, in the past five (5) years, made — or is any proposed insured contemplating making — flights as a pilot, student pilot, crew member, or observer?  Yes  No (If "Yes," complete and submit the appropriate questionnaire.)
- d. Has any proposed insured, in the past five (5) years, engaged in — or does any proposed insured intend to engage in — any hazardous avocation or sport, such as SCUBA diving, parachuting, hang-gliding, vehicle racing, or other hazardous avocation(s)?  Yes  No (If "Yes," complete and submit the appropriate questionnaire.)
- e. Has any proposed insured, in the past five (5) years, been convicted of a felony?  Yes  No (If "Yes," give details including county and state of conviction.)

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- f. Is any proposed insured currently on parole or probation?  Yes  No (if "yes", give details.)

---

- g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?.....  Yes  No
- h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks?.....  Yes  No  
(If "Yes," complete and submit the Foreign Travel Questionnaire.)

**Primary Proposed Insured**

- i. Driver's license number: | \_\_\_\_\_ State: | \_\_\_\_\_
- j. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?.....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_
- k. Do you have any other moving violations in the last five (5) years? .....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_

**Additional Proposed Insured**

- l. Driver's license number: | \_\_\_\_\_ State: | \_\_\_\_\_
- m. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?.....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_
- n. Do you have any other moving violations in the last five (5) years? .....  Yes  No  
(if "yes", give details.) | \_\_\_\_\_



## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

## APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declares for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true. They also agree that: (1) these answers as written: (i) were given to induce the company to issue a policy; and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial number as this application, no policy will be effective until it is: (i) issued; (ii) delivered to the applicant; and (iii) the full first premium paid, all during the lifetime and good health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be effective unless agreed to by the applicant in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and (5) only the president or a vice president or secretary of the company has the authority to waive any of the company rights or requirements or to waive or alter any of the provisions of: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

## FRAUD STATEMENT

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.

## FCRA / MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

## APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

### For Indexed Universal Life:

**I understand that I am applying for an indexed universal life policy and that while the value of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investment.**

### For Variable Universal Life:

**I understand that I am applying for a Variable Universal Life Policy. The accumulation value may increase or decrease depending on investment returns and the death benefit may be variable or fixed depending on the death benefit option selected.**

Date: Month/Day/Year

08/31/2011

Signed at: City

ANYTOWN

State Country

AR USA

Witnessed by: Signature of licensed agent

X e-signed by John Agent

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

X e-signed by John Doe

Print agent's name

JOHN Q AGENT

Signature of additional person(s) proposed for insurance

X \_\_\_\_\_

Agent's state license number

AR-9999999

Signature of additional person(s) proposed for insurance

X \_\_\_\_\_

Agent's company personal code

X9999

Signature of owner if other than proposed insured

X \_\_\_\_\_



19. SOLICITING AGENT'S REPORT: THESE QUESTIONS MUST BE ANSWERED IN EVERY CASE

- a. How long have you personally known the proposed insured? Years | 1 Months | 1
b. By whom will premiums be paid? Owner Applicant Other
c. What is your estimate of the premium payor's annual income? \$ 200,000 and worth? \$ 400,000
d. If the proposed insured is a child, how much insurance does the Parent/Premium Payor have in force on his/her own life?
e. Give any other surname(s) used by any proposed insured in the last five years.
f. If beneficiary is not a relative, explain insurable interest.
g. Did you see each person proposed for insurance when the application was completed? Yes No
h. Was beneficiary present during the completion of the application? Yes No
i. As agent, do you certify that, on the date of this application, you asked the proposed insured each question in the application, recorded the answers given you, witnessed such person's signature, and collected the initial premium shown in the application? Yes No
j. Do you have knowledge of any health history of any proposed insured not listed on this application? Yes No
k. As agent, did you determine this applicant's insurable objective and/or financial need? Yes No
l. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? Yes No
m. As agent, have you complied with state replacement regulations? Yes No
n. As agent, did you include individualized sales proposals in your presentations? Yes No
o. If a child, are there any other minor age siblings in the home? Yes No

Dated at: City ANYTOWN Month/Day/Year 08/31/11
Corporation name Tax ID Social Security number 333-33-3333
Branch office number and PSO code Agent personal code or number X9999 CSSD District Code 2 Agency #
Licensed agent's signature Agent e-mail JOHNQAGENT@MYEMAIL.COM Telephone number (999) 666-6666

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

If prior quote was reviewed, please provide quote number:
Additional policy plan and amount \$
Alternate policy plan and amount \$
Are commissions to be split? Yes No
Agent name Personal code or number Agent name Personal code or number
Special Instructions:

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:
Oral fluid test collected by agent Yes No Date collected? Lab ticket attached or affix barcode here:
Inspection ordered Yes No
Exam by physician, full blood, HOS EKG X-ray Paramed, full blood, HOS Full blood, physical measurements, HOS
Paramed, HOS Other
Name of approved paramed company?
Were medical records (APS) ordered by producer? Yes No
Did you pay for the attending physician's statement? Yes No
Has the application been reviewed for omissions and errors? Yes No



**22. NUMBER OF APPLICATIONS**

Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National? .....  Yes  No  
(If "Yes," give the serial number on the other application(s).)

**23. NOTES TO UNDERWRITER**

**24. BILLING DATA**

a. Mode:  Annual  Semiannual  Quarterly  Monthly  Single premium  
b. Method:  Direct: (Fill in name and address where premium notices are to be sent, ONLY IF OTHER than those of primary proposed insured.)

Name \_\_\_\_\_  
Number/Street \_\_\_\_\_ City \_\_\_\_\_  
State ZIP \_\_\_\_\_ Country \_\_\_\_\_

Electronic fund transfer (EFT): (Complete "Electronic Fund Transfer" section 25 and attach a void check.)

MDO

Salary deduction: Name \_\_\_\_\_ Number \_\_\_\_\_  
 Biweekly Amount | \_\_\_\_\_

Government allotment: Payee name

- A. Copy of certified allotment attached to application
- B. Certified copy of Form 902 completed in lieu of allotment copy
- C. Cash with application — No allotment copy
- D. C.O.D. — Defer issue until allotment begins.

Rank | \_\_\_\_\_ Branch | \_\_\_\_\_ Social Security number | \_\_\_\_\_

Special dating instructions: Issue age | \_\_\_\_\_ Issue date | \_\_\_\_\_

**25. ELECTRONIC FUND TRANSFER (EFT) INFORMATION: ATTACH "VOID" SPECIMEN OF CHECK**

Name of premium payor who will pay premium \_\_\_\_\_ Social Security number \_\_\_\_\_

Name(s) of insured(s) \_\_\_\_\_

Account number:  Checking  Savings \_\_\_\_\_ Specify desired date for draft against account \_\_\_\_\_

Bank name \_\_\_\_\_ Branch name \_\_\_\_\_ Bank transit number \_\_\_\_\_

Bank address: Number/Street \_\_\_\_\_ City \_\_\_\_\_ State ZIP \_\_\_\_\_

The undersigned requests the above-named bank to honor debit entries, either by electronic or paper means, to my account and payable to American National Insurance Company of Galveston, Texas. I agree that there will be no liability, on your part, for any reason whatsoever, for payment or failure to pay any such debit item. If, at any time, I do not have on deposit, in said bank, available funds sufficient to pay such debits, the pre-authorized payment privilege shall be automatically discontinued. Premiums then due or becoming due thereafter must be paid in accordance with one of the other methods of premium payment available to the policyowner. It is understood and agreed that all debit entries are accepted by the Company subject to their being honored upon presentation.

Date: Month/Day/Year \_\_\_\_\_ Signature of premium payer \_\_\_\_\_  
**X** \_\_\_\_\_

Agent  
**X** \_\_\_\_\_



**CONDITIONAL RECEIPT**

**THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.**

**AMERICAN NATIONAL INSURANCE COMPANY  
One Moody Plaza, Galveston, Texas 77550-7947**

**PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL INSURANCE COMPANY.  
DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

I have received \$ 488.85 in connection with an application for life insurance bearing the same serial number as this receipt. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

- (1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
- (2) All medical examinations and tests required under the company's initial application requirements must be completed and the reports of those medical examinations and tests must be received at the company's home office within 45 days after the date of this receipt;
- (3) On the effective date, as defined below, all persons proposed for insurance must be in good health and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
- (4) There is no material misrepresentation in the application.

**MAXIMUM AMOUNT LIMITATION:** At no time and in no event shall the total liability of the company under this receipt and all other receipts providing conditional insurance coverage with the company on the lives of all the persons proposed for insurance exceed \$500,000.

**EFFECTIVE DATE MEANS THE LATEST OF:** (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

**REFUND OF PAYMENT:** If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the company's liability is limited to a refund of the amount paid. Only the president, a vice president or secretary of the company has the authority to waive any of the company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

Date: Month/Day/Year	Signed at: City	State	Country
<u>08/31/2011</u>	<u>ANYTOWN</u>	<u>AR</u>	<u>USA</u>

Signature of licensed agent  
**X** \_\_\_\_\_

I have read this conditional receipt. It has been explained to me by the agent.

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)  
**X** \_\_\_\_\_

Signature of Owner  
**X** \_\_\_\_\_

**AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED.**

**AMERICAN NATIONAL INSURANCE COMPANY**  
**One Moody Plaza, Galveston, Texas 77550-7947**

Thank you for considering American National Insurance Company as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

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

Upon receipt of a request from you, MIB will arrange disclosure of any information 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, Suite 400, Braintree, MA 02184-8734.

The American National Insurance Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**Fair Credit Reporting Act Pre-notification** — Federal and state laws require 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 the proper identification, you may inspect, or, for the appropriate fee, 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 your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of 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.



Amber L. Adams, Product Development Attorney  
Product Development – Actuarial  
Home Office : One Moody Plaza, 14<sup>th</sup> Floor  
Galveston, Texas 77550

e-mail: amber.adams@anico.com  
Phone: (409) 763-4661 x 5479  
Fax: (409) 766-6933

August 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:  
Electronic Application Process for Form 10193  
SERFF Tracking Number: AMNA - 127388971  
Company Tracking Number: iPipeline E-App**

Dear Reviewer:

This is an update to the previously approved application listed above, approved on March 2, 2009, under SERFF tracking number AMNA-125968137 and state tracking number 41678. No changes have been made to the application form. However, we would like to utilize the application in an electronic form. The Agent will ask the applicant all the questions on the application and enter the applicant's answers into the computer. The questions will be identical to the ones in the currently approved application.

This application will be used with currently approved life insurance forms, including:

Whole Life  
Term Life  
Universal Life  
Indexed Universal Life  
Variable Universal Life

The authentication of the e-transaction is as follows:

American National Insurance Company will be collecting electronic signatures on life insurance forms via a process known as eSignature (Click Wrap). This process enables individual signers to review forms and attach electronic signatures via email, eliminating the need for "wet signatures" on applications.

After the application has been locked, the processes to define signature parties, gather signatures from those parties, and ultimately submit a completed application package to American National Insurance Company is defined below.

Upon initially reaching the end of the application process, the agent is presented with a dynamic screen called "Validate and Lock" that allows them to do one of two things – return to areas of the application that are not in Good Order, or lock the application if it's in Good Order.

The eSignature instructions screen displays the signing parties' names. It also requires the agent to enter the last 4 digits of their Social Security Number, which they will need, to log in when it is time to affix their electronic signature to the application. The agent is also required to enter the Email address for notifications and confirm the same. After the agent has initiated the eSignature process, the signature party will receive an email with a link to view the applicable documents. The signing party will need to enter the last four digits of their ssn to access the documents they are to review and sign.

Once the agent has locked an application and chosen to utilize the electronic signature process, the agent goes through a series of steps to identify the particular email that each signing party will use and then send that email to the party.

The URL contained in this email will last for seven calendar days until expiration. In addition, the URL will expire if any of the following events happen:

Successful completion of the eSignature process

Any signer completely declines the eSignature process  
Regeneration of a new email to the same party  
Completion of three unsuccessful login attempts

If changes are needed to the application once the signature process has begun, all signatures are voided and the signature process must begin again.

After all signing parties (Insured and/or Owner) complete the signature process successfully, an email is sent to the agent informing them as such, and that it is time for the agent to affix their signature to the forms. This email contains the URL that the agent will click on in order to start their eSignature process.

The agent's signature process begins as he/she receives an email indicating all other required signatures have been obtained. The agent's signature process cannot begin until all non-agents signatures have been applied; therefore, if a decline or expiration takes place for an insured or owner, the agent could not begin the eSignature process. After the agent reviews the Terms of Use and Application, the producer "Apply eSignature" screen is displayed. This screen is functionally similar to the Primary Insured/Owner version, with different text. The Agent will enter Signed at City and click "Apply eSignature" button. After clicking "Apply eSignature" the screen will refresh and display a link to "Print Signed Application" and a button to "Submit to ANICO". If one of the signing parties did not consent to the eSignature method, the agent could print the application and supplemental forms for a wet signature.

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

- Payment of any required filing fee
- A "John Doe" version of an electronic application
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Please let me know if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Ams", written in a cursive style.

Amber L. Adams  
Product Development Attorney