

SERFF Tracking Number: AMNA-128439521 State: Arkansas
Filing Company: American National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: iPipeline - Face to Face
Project Name/Number: /

Filing at a Glance

Company: American National Insurance Company

Product Name: iPipeline - Face to Face

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMNA-128439521 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num:

For Informational Purposes

Co Tr Num:

Author: Amber Adams

Date Submitted: 06/01/2012

State Status: Closed-Accepted for
Informational Purposes

Reviewer(s): Linda Bird

Disposition Date: 06/05/2012

Disposition Status: Accepted For
Informational Purposes

Implementation Date:

Implementation Date Requested: 06/15/2012

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: 05/23/2012

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 06/05/2012

State Status Changed: 06/05/2012

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:

Updated Electronic Application Process for Form 10193

SERFF Tracking Number: AMNA - 128439521

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Dear Reviewer:

This is an update to the previously approved electronic application process for the application listed above, approved on September 8, 2011. No changes have been made to the electronic application process. This update is to add two new e-signature processes.

The digital signing pad method works as follows:

Once the application is validated and locked, the eSignature instructions screen displays all eSignature methods available to the agent. The agent will select the digital signing pad method.

Each party reviews the application forms.

Each party must agree to the use of electronic signatures. Upon agreement to the Terms of Use, each party is prompted to sign the digital pad. The image of the signature is digitally stored and applied to all applicable documents.

If it is necessary to make a change to the application once the signature process has begun, all signatures are voided and must be obtained again once all the changes are made.

The agent is not able to sign the application until all parties have signed. Once the agent signs the application, the screen will refresh and display a link to "Print the Signed Application" and a button to "Submit to ANICO".

The face to face method works as follows:

Once the application is validated and locked, the eSignature instructions screen displays all eSignature methods available to the agent. The agent will select the face to face method.

Each party is asked to provide photo identification and respond to two personally identifiable questions; e.g. mother's maiden name.

Each party then agrees to the terms and conditions of the electronic signature process.

The parties are presented with an electronic list of forms in which their electronic signature will be applied.

The applicant must click the "Review Application" button and view all documents before an electronic signature can be applied. Once all documents are reviewed, each party clicks on a check box (radio button) noting their acceptance of

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the use of electronic signatures. Once acknowledged, each party clicks the "Apply Signature" button to finalize the process.

If it is necessary to make a change to the application once the signature process has begun, all signatures are voided and must be obtained again once all the changes are made.

The agent is not able to sign the application until all parties have signed. Once the agent signs the application, the screen will refresh and display a link to "Print the Signed Application" and a button to "Submit to ANICO".

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

Payment of any required filing fee

Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

State Narrative:

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

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

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---------|--------|----------------|---------------|
|---------|--------|----------------|---------------|

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American National Insurance Company \$100.00 06/01/2012 59629700

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|--|------------|------------|----------------|
| Accepted For Linda Bird Informational Purposes | | 06/05/2012 | 06/05/2012 |

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Disposition

Disposition Date: 06/05/2012

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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State: Arkansas

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Product Name: iPipeline - Face to Face

Project Name/Number: /

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|----------------------------|----------------------|-----------------------------|----------------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Cover Letter | | Yes |

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Supporting Document Schedules

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

| | Item Status: | Status Date: |
|---|--------------|--------------|
| Satisfied - Item: Application Comments: Attachment: Form 10193-AR.pdf | | |

| | Item Status: | Status Date: |
|---|--------------|--------------|
| Satisfied - Item: Cover Letter Comments: Attachment: AR.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> |
|---------------|--------------------------------|-------------------|
| Form 10139-AR | Application for Life Insurance | 50 |

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

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?
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?
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?
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)?
e. Has any proposed insured, in the past five (5) years, been convicted of a felony?
f. Is any proposed insured currently on parole or probation?
g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?
h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks?

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?
k. Do you have any other moving violations in the last five (5) years?

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?
n. Do you have any other moving violations in the last five (5) years?



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) |
| X _____ | X _____ |

| | |
|--------------------|--|
| Print agent's name | Signature of additional person(s) proposed for insurance |
| _____ | X _____ |

| | |
|------------------------------|--|
| Agent's state license number | Signature of additional person(s) proposed for insurance |
| _____ | X _____ |

| | |
|-------------------------------|---|
| Agent's company personal code | 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 | _____ 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) _____



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, 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.



Amber L. Adams, Product Development Attorney
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Fax: (409) 766-6933

May 23, 2012

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:
Updated Electronic Application Process for Form 10193
SERFF Tracking Number: AMNA - 128439521
Company Tracking Number: iPipeline – Face to Face**

Dear Reviewer:

This is an update to the previously approved electronic application process for the application listed above, approved on September 8, 2011. No changes have been made to the electronic application process. This update is to add two new e-signature processes.

The digital signing pad method works as follows:

Once the application is validated and locked, the eSignature instructions screen displays all eSignature methods available to the agent. The agent will select the digital signing pad method.

Each party reviews the application forms.

Each party must agree to the use of electronic signatures. Upon agreement to the Terms of Use, each party is prompted to sign the digital pad. The image of the signature is digitally stored and applied to all applicable documents.

If it is necessary to make a change to the application once the signature process has begun, all signatures are voided and must be obtained again once all the changes are made.

The agent is not able to sign the application until all parties have signed. Once the agent signs the application, the screen will refresh and display a link to "Print the Signed Application" and a button to "Submit to ANICO".

The face to face method works as follows:

Once the application is validated and locked, the eSignature instructions screen displays all eSignature methods available to the agent. The agent will select the face to face method.

Each party is asked to provide photo identification and respond to two personally identifiable questions; e.g. mother's maiden name.

Each party then agrees to the terms and conditions of the electronic signature process.

The parties are presented with an electronic list of forms in which their electronic signature will be applied.

The applicant must click the "Review Application" button and view all documents before an electronic signature can be applied. Once all documents are reviewed, each party clicks on a check box (radio button) noting their acceptance of the use of electronic signatures. Once acknowledged, each party clicks the "Apply Signature" button to finalize the process.

If it is necessary to make a change to the application once the signature process has begun, all signatures are voided and must be obtained again once all the changes are made.

The agent is not able to sign the application until all parties have signed. Once the agent signs the application, the screen will refresh and display a link to "Print the Signed Application" and a button to "Submit to ANICO".

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

- Payment of any required filing fee
- 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". The letters are stylized and connected.

Amber L. Adams
Product Development Attorney