



APPLICATION FOR LIFE INSURANCE
Part 1

Issue Date \_\_\_\_\_

1. Employer \_\_\_\_\_ Plan/Dept. \_\_\_\_\_ Franchise Number \_\_\_\_\_

PRIMARY PROPOSED INSURED (Employee)
Male Female Employee Social Security No.
Home Address Street City State ZIP Telephone No. Home
Occupation Annual Income Date Employed (Mo./Year) Work
Date of Birth Age ( )

2. Plan of Insurance: \_\_\_\_\_ Specified Amount \$ \_\_\_\_\_
Death Benefit Option A B Dividend Option \_\_\_\_\_ Premium \$ \_\_\_\_\_ per month (include any riders)

3. Beneficiary - Name and Relationship. If none, beneficiary will be Owner or Owner's Estate.
Owner (If other than Employee) Owner's Address/Social Security No. & Age

4. RIDERS: Spouse's Term Rider \$ Children's Term Rider \$ Level Term Rider \$
ADB - Death Benefit \$ Waiver of Minimum Premium Other \$

Table with 6 columns: Complete if spouse's or children's rider is applied for, Name, Son/Daughter/Spouse, Date of Birth (Mo./Day/Year), Name, Son/Daughter/Spouse, Date of Birth (Mo./Day/Year)

5. Is this insurance intended to replace or change any existing life insurance or annuity in any company, association or society? Yes No

6. a. Has any person proposed for insurance missed 3 or more consecutive days of work or normal activity due to illness or injury during the last 120 days? Yes No Employee Spouse Child

b. To the best of your knowledge and belief: Have you or any person proposed for insurance ever had, been told you had or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related condition? Yes No Employee Spouse Child

c. Is the employee actively at work as of this date? Yes No

d. Has any person proposed for insurance used tobacco in any form during the past 12 months? Yes No
If yes, who: \_\_\_\_\_

If 6a or 6b is answered "Yes" or 6c is answered "No," for any Proposed Insured, complete Application For Life Insurance Part 2 for that Proposed Insured. (If Part 2 is completed, Primary Proposed Insured (Employee) will sign Part 2 Declaration.)

DECLARATION

To the best of my knowledge and belief, I acknowledge that the statements and answers given are true and correct for all Proposed Insureds. The insurance applied for will be effective upon the issue date of the policy. Providing there is no material misrepresentation in the application, if the payroll deduction is authorized, effective immediately, interim life insurance equal to the lesser of the amounts applied for or \$100,000 is provided on all applicants unless the answer to question 6a or 6b is "Yes" or 6c is "No". This coverage continues until this application has been approved for issue, or until you are notified that no insurance will be issued. I understand that only an officer of the Company's Home Office may make or modify contracts or waive any rights or requirements and then only in writing. No change may be made in the amount of insurance, premium, classification of risk, plan of insurance, or benefits, without written consent of the Primary Proposed Insured and Owner.

Agent's Report: Do you have knowledge or reason to believe that replacement of existing insurance may be involved? Yes No

If "Yes," explain by memorandum.

I hereby certify that I have personally asked each question on the application to the Primary Proposed Insured (Employee), and I have truly and accurately recorded on the application the information supplied by him/her.

Dated at \_\_\_\_\_ on \_\_\_\_\_
City State Month Day Year

Signature of Primary Proposed Insured (Employee)

Print Witness Name

Signature of Owner/Trustee If Qualified Plan

Signature of Witness (Agent)

Branch Office No. \_\_\_\_\_ Agent P.C. No. \_\_\_\_\_ License I.D. # \_\_\_\_\_

**APPLICATION FOR LIFE INSURANCE - PART 2**

Primary Proposed Insured (Employee)

Proposed Insured For Whom Part 2 Is Required

|   |                              |
|---|------------------------------|
| Height ft. _____ in. _____ Weight _____ | Birthplace/Birth State _____ |
|---|------------------------------|

|  |   |
|--|---|
| <p><b>7. HAS ANY PROPOSED INSURED:</b></p> <p>a. Ever had or been diagnosed or treated for any abnormality, deformity, disease or disorder or presently receiving treatment or taking medicine of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Ever had a surgical operation or been advised to have an operation which was not performed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Ever had an x-ray, electrocardiogram, blood or urine test or other laboratory test? If "Yes" state why, when, where, and by whom. <b>DO NOT REVEAL ANY INFORMATION RELATING TO AIDS.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Ever made claim for or received any insurance benefit, compensation or pension, government or otherwise, on account of an injury or sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Any impairment of sight or hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Ever been under observation or treatment in any hospital, sanitarium, convalescent or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Ever received counseling or treatment regarding the use of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>h. Ever used barbiturates, amphetamines, hallucinatory drugs, heroin, opiates or other narcotics, except as prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Ever had or been treated for high or low blood pressure, chest pain or for sugar in the urine; or for cancer in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. To the best of your knowledge and belief: Have you or any person proposed for insurance ever had, been told you had or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Consulted, been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Is Proposed Insured now in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>m. If any Proposed Insured is less than one year old, give birth weight. _____ lbs. _____ oz. Was birth considered premature? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

8. Give full details below of all "Yes," answers to question 7 a-k & m and if answer is "No" on 7l.

| Person | Question number | Reason, condition disease, or injury, etc. | Date | Degree of recovery | Name and address of attending physicians (Street, City, State) |
|--------|-----------------|--|------|--------------------|--|
|        |                 |  |      |                    |  |
|        |                 |  |      |                    |  |
|        |                 |  |      |                    |  |
|        |                 |  |      |                    |  |

**DECLARATION**

**To the best of my knowledge and belief, I acknowledge that the answers set forth above are true and correct with respect to all Proposed Insureds.** I agree that:

1. The answers recorded on this agreement are the basis for issuing this policy applied for; and
2. The effective date of this coverage will be the date this application is signed, subject to the following:
  - a. The payroll deduction is authorized or the first full mode premium is paid on the date of the application (any payment submitted must be honored on its first presentation for payment),
  - b. The proposed insureds must be insurable under the Company's rules on the plan and for the amount applied for, and
  - c. There is no material misrepresentation in the application, and

d. The maximum amount of insurance which may become effective prior to delivery of the policy will be the lesser of: (1) the amount of basic insurance applied for or (2) \$100,000;

Otherwise, no coverage will become effective unless a policy is delivered to and accepted by the Primary Proposed Insured while the answers to the above questions remain the same and when the full first premium for the insurance applied for has been paid.

I understand that only an officer of the Company's Home Office may make or modify contracts or waive any rights or requirements and then only in writing. No change may be made in the amount of insurance, premium, classification of risk, plan of insurance or benefits, without written consent of the Primary Proposed Insured and Owner.

Dated at \_\_\_\_\_ on \_\_\_\_\_

City State Month Day Year

\_\_\_\_\_  
Signature of Primary Proposed Insured (Employee)

\_\_\_\_\_  
Signature of Owner/Trustee  
If Qualified Plan

I hereby certify that I have personally asked each question on the application to the Primary Proposed Insured (Employee) and I have truly and accurately recorded on the application the information supplied by him or her.

\_\_\_\_\_  
Signature of Witness (Agent)

**AGENT: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE PRIMARY 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 may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112.

The American National Insurance Company, or its reinsurers, may also release information in 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.

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.

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

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of the health of any proposed insured, to give to American National Insurance Company or its Reinsurers any such information about any proposed insured with reference to our health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I have received notification describing the Medical Information Bureau, and this authorization will be valid for two (2) years from its date.

To facilitate rapid submission of such information, I authorize all the above sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by American National Insurance Company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Primary Proposed Insured (Employee)

\_\_\_\_\_

Witness