

**Application to
American National Life Insurance Company of Texas (ANTEX) • Home Office • Galveston, Texas**

Print in Black New Reinstatement-Existing # _____ Change-Existing # _____

1. Special Requests: Mail Policy to Applicant: Yes No Requested Effective Date: _____

I apply for:

2. **Catastrophic Hospital Plan:**

Option A

Deductible Amount:

- \$750 \$1,500 \$2,000 \$2,500 \$5,000
 \$10,000 \$15,000 \$20,000 \$25,000

PPO Rider Yes No

PPO Selected _____

Option B (Family Coverage only)

Deductible Amount:

- \$3,000 \$4,000 \$5,000
 \$10,000

Optional Benefits: (NON-HSA ONLY)

Accident Rider:

Max. Amount Deductible

- \$500 \$100
 \$1,000 \$250
 \$1,500 \$250
 \$2,500 \$500

OP Diagnostic Testing Rider: Yes* No

Deductible Amount: \$750 \$1,000 \$1,500

OP Drug Rider: Yes No

- \$500 \$1,000 (Individual Deductible)
 \$1,000 \$2,000 (Family Deductible)

OP Doctor Rider: Yes** No

Deductible Amount: \$750 \$1,000 \$1,500
Maximum Benefit: \$25,000 \$100,000

Critical Illness Beneficiary:

Name: _____ Relationship: _____

*(Not available when OP Doctor Rider selected) **(Not available when OP Diagnostic Testing Rider selected.)

Rate of Payment:

- 100% 80% 50%

Stop-Loss Amount: (Option A only)

- \$5,000 \$10,000

Per Injury/Sickness Maximum

- \$1,000,000 \$2,000,000

HSA Plan:

Plan Deductible Amount:

Individual: \$1,500 \$2,000

- \$2,500 \$5,000

Family: \$3,000 \$4,000 \$5,000

- \$10,000 (100% Rate of Pmt.)

Rate of Payment:

- 100% 80% 50%

Per Injury/Sickness Maximum

- \$1,000,000 \$2,000,000

PPO Rider Yes No

PPO Selected _____

Decreasing Term Insurance: (Optional. If elected, a separate policy is issued.)

- Yes No Individual Family

Beneficiary: _____ Relationship: _____

If 'yes,' is this insurance intended to replace any existing life insurance? Yes No

Initial Modal Premium:

Health Premium Amount: \$ _____

Life Premium Amount: \$ _____

3. **Proposed Insured Information** (TO BE COMPLETED PERSONALLY BY THE APPLICANT AND SPOUSE, IF ANY.)

Proposed Insured(s) (Print Last Name, First Name, MI.)	Relationship	Marital Status		Sex	Age	Date of Birth			Place of Birth	Build		Social Security Number
		Single	Married			Mo.	Day	Year		Height	Weight	
1	Applicant	<input type="checkbox"/>	<input type="checkbox"/>									
2	Spouse	<input type="checkbox"/>	<input type="checkbox"/>									
3												
4												
5												
6												

4. **Address** (Applicant's)

Number and Street or R.F.D. _____

City _____ State _____ Zip _____

Phone: Hm () _____ A.M. P.M.

Work: () _____ A.M. P.M.

Cell: () _____ A.M. P.M.

E-Mail Address: _____

Best time to call:

5. Employment Data	Full-Time?	Name of Employer	Duties/Title	Avg. Mo. Earnings Last 12 Months
Applicant	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ _____
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ _____

THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU IS NOT DESIGNED NOR INTENDED AS A HEALTH INSURANCE PLAN TO BE PROVIDED BY AN EMPLOYER FOR EMPLOYEES.

CHANGES IN STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE. ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

1. Is the Applicant or Spouse the owner of an incorporated business? Yes No
2. Is the Applicant or Spouse a sole proprietor or a partner in a partnership? Yes No
3. Is the Applicant or Spouse an employee of a business? Yes No
 - a. Will the Applicant's or Spouse's employer pay a portion of your health insurance premium? Yes No
 - b. Will the Applicant or Spouse be reimbursed by employer, through wage adjustments or otherwise, for any portion of the premium? Yes No
 - c. Will the Applicant's or Spouse's health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)? Yes No

6. Is any Proposed Insured or household member (including students away at school, whether or not now applying for coverage) currently pregnant?
 Yes No (If "Yes", this coverage cannot be provided.) _____

7. Has any Proposed Insured used any type of tobacco (including cigarettes, cigars, and/or smokeless tobacco) during the past 12 months?
 Yes No (If "Yes", state whom, and details.) _____

8. Are all Proposed Insureds legal citizens of the United States? Yes No
 If "No", is the such Proposed Insured a permanent resident? Yes No (If "No", this coverage cannot be provided).

9. Does any Proposed Insured intend to travel or reside outside the U.S.A.? Yes No
 If "Yes", give details _____

10. Are all your dependent children under the age of 26? Yes No
 (Do not include on this application any of your children who are 26 years of age or older or any married children).

11. Is any proposed insured applying under the HIPAA mandate? Yes No (If "Yes", attach a copy of Certificate of Creditable Coverage)
12. Do you have another insurance policy or contract in force? Yes No If so, with which Company?
13. Do you intend to replace your current accident and sickness insurance with this policy/contract? Yes No
14. Do you have any other accident and sickness insurance that provided benefits similar to this accident and sickness policy? Yes No (If "Yes", complete the following)

Company & Policy Number	Type of Policy	Termination Date

15. Are you covered for medical assistance through the state Medicaid program:
 - A. As a specified Low Income Medicare Beneficiary (SLMB)? Yes No
 - B. As a Qualified Medicare Beneficiary (QMB)? Yes No
 - C. For other Medicaid Benefits? Yes No

16. List policies sold by writing agent still in force: _____

17. List policies sold by writing agent within the past five (5) years which are no longer in force: _____

18. Has any Proposed Insured applied for life, accident or health insurance, or reinstatement of such insurance, which was declined, restricted, postponed, rescinded, cancelled, withdrawn, or modified as to plan, amount, coverage, or rate? Yes No (If "Yes", give details)

19. Within the past 2 years, has any Proposed Insured made claim or received benefits for any injury or sickness in the last 12 months; or are they presently receiving any government aid such as Medicaid, Medicare, or SSDI? Yes No (If "Yes", state whom, name of insurer, month, year, and nature of ailment)

20. Has any Proposed Insured ever taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting an aircraft, or rodeo events? Yes No (If "Yes", indicate activity and give details.)

21. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's or been arrested within the past 2 years?
 Yes No (If "Yes", give details and provide Driver's License # and state of issue)

22. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Proposed Insured:

Proposed Insured	Condition, injury symptoms, diagnosis & treatment	Onset Date Month/Year	Date of last treatment	Results/Degree of recovery	Physician Name/Address

**THE FOLLOWING QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.
ANY MISSTATEMENTS MAY AFFECT YOUR COVERAGE — GIVE FULL DETAILS TO ALL “YES” ANSWERS IN THE SPACE PROVIDED.**

- | | |
|---|---|
| <p>23. Within the last 10 years, has any Proposed Insured had any indication of, diagnosis of, or treatment for:</p> <p>a. A respiratory or lung disorder, for example, allergies, sinusitis, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, or emphysema;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. A circulatory or heart disorder, for example, high blood pressure, high cholesterol, heart attack, heart valve disorder, murmur angioplasty/bypass, chest pain, irregular heart rhythm, varicose veins, phlebitis or stroke;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. An immune, blood or spleen disorder, for example, anemia, leukemia, lymphoma, connective tissue disease, lupus, scleroderma, or clotting disorder;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. A digestive or gastrointestinal disorder, for example, ulcer, gastritis, reflux disorder, hepatitis, Crohn's Disease, ulcerative colitis, cirrhosis, irritable bowel, hemorrhoids, hernia or any disorder of the pancreas, liver, rectum or gallbladder; <input type="checkbox"/> <input type="checkbox"/></p> <p>e. A nervous disorder, seizures, tremors, headaches, paralysis, palsy or injury of the brain, spinal cord, or nerves;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>f. A mental disorder, for example, emotional problems, eating disorder, attention deficit disorder, anxiety, depression, autism, sleep disorder, or received psychiatric treatment or counseling;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>g. An endocrine disorder, for example, diabetes mellitus or insipidus, low or high blood sugar, disorder of the thyroid, parathyroid, pituitary, or adrenal glands;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>h. A urinary tract disorder, for example, urinary tract stone, bladder or kidney infections, renal reflux, incontinence, or blood in the urine;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>i. A muscular or skeletal disorder, for example, arthritis, gout, fibromyalgia, bone, joint, muscle, back, spine disorder, disc disease, sciatica, or received chiropractic treatment or acupuncture;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>j. A facial bone or jaw disorder, for example, birth defect, congenital anomaly, malformation, temporomandibular joint disorder (TMJ), physical deformity, cleft palate or lip;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>k. Cancer in any form, tumor, cyst, polyp, or growth of any kind;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>l. An eye, ear, nose, throat disorder, for example, glaucoma, cataracts, ear infections, ear tubes, hearing impairment, enlarged tonsils/adenoids, vertigo, sleep apnea or deviated nasal septum;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>m. A skin or subcutaneous tissue disorder, for example, burns, scars or hemangioma;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>n. Mental or physical impairment or deformity; or congenital abnormality, mental retardation, developmental delay; or trait not previously disclosed;..... <input type="checkbox"/> <input type="checkbox"/></p> <p>o. For Male Proposed Insureds Only:
A male reproductive disorder, for example, disorder of the prostate, testicles, elevated PSA, or a sexually transmitted disease;..... <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No</p> <p>p. For Female Proposed Insureds (18+) Only...</p> <p>i. Any disorder or condition of the female reproductive organs, for example, abnormal Pap Smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean section delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, or a sexually transmitted disease, or HPV (human papilloma virus); <input type="checkbox"/> <input type="checkbox"/></p> <p>ii. Date of last Pap Smear _____
Results _____</p> <p>iii. Had instructions to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear; or..... <input type="checkbox"/> <input type="checkbox"/></p> <p>iv. A breast disorder, disease, changes, or condition, lump(s) aspiration(s), calcifications, biopsies, removal or placement of breast implants, or mammoplasty?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Within the last ten (10) years, has any proposed insured:
a. Been diagnosed as having AIDS or AIDS-related condition?..... <input type="checkbox"/> <input type="checkbox"/>
b. Received a positive result on an HIV test?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>25. Does any Proposed Insured have a prosthetic device present, for example, plates, screws, pins rods, implants, shunts, pacemakers, valve replacements or stents or fixation devices?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Within the past 5 years, has any Proposed Insured:
a. Had surgery, been hospital confined, or advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery; or..... <input type="checkbox"/> <input type="checkbox"/>
b. Had a heart, bone, or blood study, MRI, x-ray, or ultrasound; or contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing healthcare services?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>27. Within the past 12 months, has any Proposed Insured experienced or been treated by a physician for a change in weight of more than 12 pounds?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>28. Has any Proposed Insured ever been:
a. Treated or counseled for alcohol or drug use, or attended a drug or alcohol support group; or..... <input type="checkbox"/> <input type="checkbox"/>
b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption; or..... <input type="checkbox"/> <input type="checkbox"/>
c. Under the influence of marijuana, narcotics, barbituates, amphetamines, hallucinogens, or used any other drugs not prescribed by a physician?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>29. Within the last six months, has any Proposed Insured taken any prescription medication or are now taking any prescription medication or receiving treatment of any kind for any condition not listed in any of the previous questions?..... <input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

COMPLETE THE FOLLOWING FOR EACH “YES” ANSWER TO QUESTIONS 23 THROUGH 29 ABOVE.

Question Number	Name of Person	Date of Treatment From	To	Reason for Check-up, Diagnosis, Illness or Condition, Frequency of Attacks	Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery	Name and Address of Each Physician, Practitioner and Medical Facility

If additional space is needed, please use the separate sheet provided, sign, date and return with the Application.

COLORADO DISCLOSURE FOR BUSINESS GROUP OF ONE

I, _____, meet the definition of a self-employed business group of one as attested to on the accompanying Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of the carrier's overall cost and utilization trends, age, gender, family size, tobacco use, a factor that reflects the cost of care where I live, and a factor that reflects my health risk as determined by the carrier's underwriting guidelines. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live.

I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

COLORADO BUSINESS GROUPS OF ONE WAIVER OF COVERAGE

If a Business Group of One is applying for medical coverage in Colorado, the carrier must accept or reject the entire family, unless the proposed insured waives coverage for a family member who has other coverage in effect.

List the names and relationship of all your dependents, whether listed on the application or not.

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I certify that the following members have other health insurance coverage in effect:

Name	Type of Coverage/Name of Provider	Effective Date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

After consideration, it is my decision to waive coverage under the American National Life Insurance Company of Texas Policy for the above family members.

Signature of Primary Proposed Insured: _____ Date: _____

DETERMINATION OF SELF-EMPLOYED BUSINESS GROUP OF ONE

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees? Yes No
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? Yes No
3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your "income" means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan. Yes No
4. Do you work a minimum of 24 hours a week on a permanent basis? Yes No

Propose Primary Insured's business: _____

Rating Classes

Only applies to Catastrophic Hospital and HSA Plans

Rating classes are determined on an individual basis - Each family member is evaluated individually.

American National Life Insurance Company of Texas uses 5 rating classes:

- ✓ **Tobacco User:** This includes any proposed insured who has used tobacco products, including smokless or chewing tobacco within the past 12 months prior to the application date.
- ✓ **Standard:** This includes proposed insureds who have not used tobacco within 12 months preceeding the application date but are not eligible or do not qualify for the Preferred Rates.
- ✓ **Substandard:** This includes proposed insureds who would require an extra premium or exclusion waiver(s) for certain health conditions that are otherwise not insurable. This allows full coverage for the health condition(s). Medical waivers are available for proposed insureds with certain conditions that are otherwise not insurable.
- ✓ **Preferred:** To be eligible for the Preferred Rate Discount, the proposed insured must be 19 years or older and applying as a primary insured or spouse. Additionally, this class includes proposed insureds who are generally healthy and lead a healthy lifestyle.
- ✓ **Preferred Tobacco User:** This includes Proposed Insureds who have used tobacco (less than 1.5 packs of cigarettes per day) within the past year and qualify medically for Preferred Rates.

If any of the following apply, preferred rates and preferred tobacco rates are not available.

- " **Medical Exclusions / Rider**
- " **Special Class Rating**
- " **Answers "Yes" to questions 1 through 7 in the Preferred Rating Questionnaire**
- " **Answers "No" to question 8 in the Preferred Rating Questionnaire**

Preferred Rating Questionnaire

	PROPOSED INSURED		SPOUSE	
	Yes	No	Yes	No
1. Have you used tobacco in any form in the past 12 months prior to the application date?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your weight fall outside the standard weight range listed on the build chart provided in the field Underwriting Manual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had blood pressure readings in excess of 140/95 and/or been treated for hypertension in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had cholesterol readings in excess of 250 and/or been treated for elevated cholesterol or triglycerides in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any convictions for OUI, DUI, DWI or more than 3 moving violations in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken any prescription medication in the past 2 years for a recurrent or chronic condition? (e.g. Reflux, Arthritis, or Asthma, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you recently applied for coverage and been turned down, rated, or offered modified coverage within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had a physical examination as required by age reflected below?: 18-39yrs no exam required, 40-49yrs exam within 3 years, 50+ years exam within 2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: The proposed insured must complete and sign the appropriate sections. Spouses are considered separately for Preferred Rating eligibility and must also answer this questionnaire. This information is not required for dependent children. Underwriting reserves the right to apply tobacco ratings based upon lab results, telephone verification or medical records.

Proposed insured _____ Date _____

Spouse _____ Date _____

Drivers license number _____ State _____

Drivers license number _____ State _____

Soliciting Agent _____ Date _____

Soliciting Agent number _____

BILLING SECTION

Payment Mode: Annual Semi-Annual Quarterly

Monthly Electronic Debit (Funds to be withdrawn from the account number shown on a CWA check, otherwise, submit a copy of a voided check or deposit slip to establish a different account for premium withdrawal.) Checking Savings

Cash collected with Application: \$ _____ Draft Initial premium \$ _____
(Drafted on Approval)

For Monthly Renewal Electronic Withdrawals:

Select a desired withdrawal day (1- 28) _____

Bank Name _____

City _____ State _____

<i>John Doe</i>		<i>231</i>
<i>123 Grey</i>		<i>Date</i> _____
<i>Hot, Tx</i>		
_____ \$		<input type="text"/>
<i>Pay to the order of</i>		
_____ Dollars		
<i>Routing No.</i>	<i>Account No.</i>	<i>Check No.</i>
<i>23898993</i>	<i>898667209</i>	<i>231</i>

Routing Number _____ Account Number _____

Credit Card CREDIT CARD INFORMATION (INITIAL PREMIUM ONLY)

Payment Amount \$ _____ VISA Mastercard Discover Card

Credit Card No.: _____ Expiration Date: _____

3 digit Security Number - Back of Card _____

Print Name of Cardholder _____

Cardholder's billing address: _____

City _____ State _____ Zip _____

Signature of Cardholder _____

Name and address of Insurance Premium Payor if other than Applicant

COLORADO NOTICE TO PROPOSED INSURED REGARDING REPLACEMENT

According to your application and the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by American National Life Insurance Company of Texas. The new policy will provide 10 days of free look period, within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO PROPOSED INSURED BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s):

(check one):

- Additional benefits
- No change in benefits, but lower premium
- Fewer benefits and lower premium
- Other (Please specify) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may be payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Proposed Primary Insured's Signature

Signature of Producer or Issuer

American National Life Insurance Company of Texas
P. O. Box 1998
Galveston, Texas 77553-1998

(Date)

(Date)

COMPENSATION DISCLOSURE NOTICE

I represent American National Life Insurance Company of Texas and will provide services to you on behalf of the Company. I will receive ____% compensation from American National Life Insurance Company of Texas for placement of the insurance for which you have applied.

Customer Acknowledgement: I acknowledge receipt of this disclosure.

Customer Signature

Date

Producer Acknowledgement: I have provided this disclosure notice to this customer.

Producer Signature

Date

**IMPORTANT INFORMATION FOR PRODUCER
RETAIN A COPY OF THIS NOTICE FOR YOUR RECORDS**

LEGAL NOTICES

Fair Credit Reporting Act (FCRA) 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 proper identification, you may inspect or 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.

Medical Information Bureau (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. American National Life Insurance Company of Texas, or its reinsurers 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 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 Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Life Insurance Company of Texas, 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996; it was effective July 1, 1997. HIPAA provides certain Americans guaranteed access to health insurance coverage regardless of existing health conditions.

Eligible Individuals are the only people who have guaranteed access to health insurance under HIPAA. Eligible Individuals must be replacing Creditable Coverage. Creditable coverage is replacement of: group sponsored health plans, individual coverage by state law, Medicaid, Medicare, plans sponsored by the US Military, Indian Health Service, a high risk pool, US Government employee plans, and Peace Corp plan. Creditable Coverage must have been in force for 18 months and be replaced within a 63-day period after it terminates (may vary by state).

HIPAA requires health insurance carriers to allow guaranteed access to certain plans (Federal Fallback) unless a state adopts an Alternative Mechanism. These include high-risk pools, guaranteed issue requirements for available plans or other methods to assure the access requirements for HIPAA are followed.

Insurance Fraud

Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any Insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

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