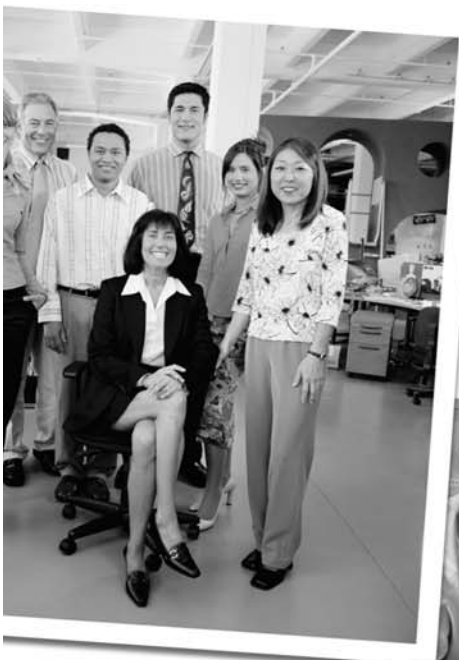




# CATASTROPHIC COMPLETE KANSAS FORMS PACKET



*from American National Life  
Insurance Company of Texas (ANTEX)*



# Notice to Applicant

This description of the Information Practices of American National Life Insurance Company of Texas is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

## Collection of Information

Federal and state laws require notification that, in accordance 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 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, 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 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.

Information regarding your insurability will be treated as confidential. American National Life Insurance Company of Texas or its reinsurer 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 claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon request from you, the Bureau will arrange disclosure of any information it may have in its file. If you question the accuracy of information in the Bureau's files, 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 P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

In some circumstances, American National Life Insurance Company of Texas will make disclosures of personal information, without your authorization, to third parties. Some of the persons or organizations to whom certain items of information might be disclosed are the agent, consumer reporting agencies hired to prepare investigative reports, our reinsurer, the Medical Information Bureau, and other insurance companies to which you have applied for coverage or benefits.

Please be assured that the above describes some of the disclosures which may be made, not disclosures which are always made. In any event, the information disclosed without your authorization will be only as much as is reasonably necessary to accomplish this intended purpose. The types of information disclosed will vary depending upon the needs of the recipient and the sensitivity of the data. A description of the circumstances under which information about you might be disclosed without your authorization, to the types of persons and organizations referred to above, will be sent to you upon request.

**Obtaining Additional Information**---We at American National Life Insurance Company of Texas hope that you find this description of our information practices helpful. We take our responsibility, and your rights, very seriously. If you have any further questions about the items discussed above, please write to us at One Moody Plaza, Galveston, Texas 77550.

**PRE-NOTICE: DELIVER TO APPLICANT PRIOR TO COMPLETION OF THE APPLICATION.**

COLINFO

**THIS NOTICE STAYS WITH THE CLIENT- DO NOT RETURN TO THE HOME OFFICE**

# Application to American National Life Insurance Company of Texas • Galveston, Texas

Print in Black    New    Reinstatement-Existing # \_\_\_\_\_    Change -Existing # \_\_\_\_\_

**1. I apply for:**

**Catastrophic Hospital Plan**

**Plan Deductible Amount:**

\$750    \$1,500    \$2,000    \$2,500  
 \$5,000    \$10,000    \$15,000

**Lifetime Maximum Benefit**

\$2,000,000    \$5,000,000  
 \$7,000,000

**Coinsurance:**

100%    80 %    50 %

**Stop-Loss Amount:**

\$5,000    \$10,000

**Optional Benefits:**

**OP Accident Rider :**

\$400    \$800    \$1,200

**OP Doctor Rider:**

YES    NO

**PPO Rider:**

YES    NO

**OP Drug Rider:**

Individual Deductible

\$500    \$1,000

**Maternity As Any Other Sickness Rider**

YES    NO

Home Office Use:

2. Special Request:

**3. 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.)  
 Draft Initial Premium  Yes  No

Amount collected with Application:

\$ \_\_\_\_\_

Name and Address of Premium Payor if other than Proposed Insured \_\_\_\_\_

**TO BE COMPLETED PERSONALLY BY THE PROPOSED INSURED AND SPOUSE, IF ANY.**

**4. Proposed Insured Information**

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

**5. Address** (Permanent U.S. residence of primary insured.)

Number and Street or R.F.D.

Phone: Hm(    ) \_\_\_\_\_      Best time to call:  A.M.    P.M.

Work: (    ) \_\_\_\_\_       A.M.    P.M.

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**6. Employment Data**

Employed Full-Time?	Name of Employer	Duties/Title	Avg. Monthly Earnings Last 12 Months
Person No. 1 <input type="checkbox"/> Yes <input type="checkbox"/> No			\$ _____
Person No. 2 <input type="checkbox"/> Yes <input type="checkbox"/> No			\$ _____

**7. 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.)

**8. 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 form of use details.) \_\_\_\_\_

**9. Are all proposed insureds U.S. Citizens?**    Yes    No (If "No", state whom and how long a resident of U.S.A.) \_\_\_\_\_

**10. Does any proposed insured, immediate family, or household member intend to travel or reside outside the U.S.A.?**    Yes    No  
 (If "Yes", give details.) \_\_\_\_\_

**11. Are all family members between the ages of 19 and 24 full time students?**    Yes    No  
 (If not a full time student, coverage must be written on an individual basis. Do not include on this application.) \_\_\_\_\_

**12. Other Insurance Information:**

- A. Are any proposed insureds covered by, or has application been made for, any type of medical insurance? ("Medical insurance" includes: Blue Cross/Blue Shield, HMO, and medical expense and indemnity policies)  Yes  No
- B. Has any proposed insured been covered under a health insurance plan including COBRA within the last 18 months?  Yes  No
- C. Is the insurance applied for intended to replace any existing insurance or insurance which has been terminated with this company or any other company?  Yes  No
- D. Has any proposed insured ever been covered by, or made application to, ANTEX for other insurance coverage? (If "Yes", give details)  Yes  No

Complete the following for each "Yes" answer to questions 12A-D above and list all medical insurance applied for or now in force. This coverage is not available in addition to other major medical plans.

Person No.	Name of Company/Policy No.	Plan Type (COBRA, Group or Individual)	Hospital Indemnity Only	Hospital			Major Medical		Effective Date	Termination Date
				Rm & Brd	Misc.	Surgical	Deductible	Maximum		

13. Are you applying for coverage under the federal HIPAA Program?  Yes  No If "Yes", please submit Letter of Creditable Coverage with the application.

14. Will proposed coverage replace or change any existing Medical insurance?  Yes  No  
 A. If Yes, give plan details above and provide reason for replacement such as carrier terminated coverage, lower rates, better coverage, etc.  
 B. **You should not cancel your existing health insurance coverage until you receive written notification of acceptance from ANTEX.** If accepted, do you agree to discontinue your current major medical plan?  Yes  No

15. Within the past 5 years has any proposed insured applied for life, accident or health insurance or for 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) \_\_\_\_\_

16. Is any proposed insured eligible for Medicare or does any proposed insured currently receive Medicare or SSI benefits?  Yes  No  
 (If "Yes", state whom and name of program)  
 \_\_\_\_\_

**Medical History and Related Information**

17. Has any proposed insured ever taken part in: skydiving, hang gliding, parachuting, bungy jumping, rock or mountain climbing, underwater diving, racing (any type); motorcycle riding; professional sports; piloting an aircraft, or rodeo events?  Yes  No  
 (If "Yes", circle activity and give details.)

18. Has any proposed insured had any arrests, a driver's license suspended, traffic violations or prior DWI/DUI/OUI's within the past 2 years?  
 Yes  No (If "Yes", give details and provide Driver's License # and state of issue)  
 \_\_\_\_\_

19. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each proposed insured:

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

**THIS QUESTION MUST BE ANSWERED COMPLETELY FOR ALL PROPOSED INSURED**

**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><b>20.</b> Within the last 10 years has any proposed insured had any indication of, diagnosis of, or treatment for:</p> <p>a. A Respiratory System disorder, including lung disease, hayfever, allergies, including desensitization, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, emphysema or sleep apnea?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. A Circulatory System and heart disorder, including high blood pressure, high cholesterol, heart attack, heart valve disease or murmur, angioplasty/bypass, stent placement, chest pain, irregular heart rhythm, varicose veins, phlebitis, transient ischemic attack, stroke?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. The Immune System disorder, including blood or spleen disorder, anemia, leukemia, bleeding disorder, lymphoma, or connective tissue disease such as lupus and scleroderma?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. A Digestive/Gastrointestinal system disorder, including ulcer, gastritis, esophagitis, reflux disorder, ileitis, cellulitis, hepatitis, cirrhosis, hemorrhoids, hernia or any disorder of the pancreas, liver, rectum or gallbladder?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>e. A Nervous System disorder, including epilepsy/seizures, tremors, headaches, paralysis, stroke, transient ischemic attack (TIA), palsy or any disorder or injury of the brain, spinal cord, or nerves?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>f. A Mental/Nervous System disorder, including emotional problems, eating disorder, attention deficit disorder, anxiety, depression, autism, sleep disorder, developmental delay, or received psychiatric treatment or counseling?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>g. An Endocrine System disorder, including diabetes mellitus or insipidus, abnormal blood sugar, hypoglycemia or any disorder of the thyroid, parathyroid, pituitary, adrenal, thymus gland?.. <input type="checkbox"/> <input type="checkbox"/></p> <p>h. A Urinary System disorder, including kidney stones, bladder or kidney infections, renal reflux, blood, sugar, or albumin in the urine or sexually transmitted disease?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>i. A Muscular/Skeletal System disorder, including arthritis, gout, rheumatism, fibromyalgia, motor skill delay, a bone, joint, muscle disorder, a back/spine disorder to include disc disease and sciatica, or received manipulative/adjustment therapy?.. <input type="checkbox"/> <input type="checkbox"/></p> <p>j. A Facial/Bone/Jaw disorder including temporomandibular joint disorder (TMJ), cleft palate/lip, overbite or underbite?.... <input type="checkbox"/> <input type="checkbox"/></p> <p>k. A Cancer in any forms including in-situ and skin, tumor, cyst, polyp, or growth of any kind?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>l. An Eye, Ear, Nose, Throat disorder, including impaired vision, glaucoma, cataracts, ears infections, ear tubes, hearing, impairment, enlarged/infected tonsils, vertigo, speech impairment or sinusitis?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>m. A Skin/Subcutaneous Tissue disorder, including burns, scars, dermatitis, acne, eczema, psoriasis, cellulitis, or hemangioma?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>n. A Male Reproductive/Breast disorder including any disorder of the prostate, testicles, elevated PSA, infertility or impotence?.. <input type="checkbox"/> <input type="checkbox"/></p> <p><b>21.</b> Within the last ten (10) years, has any proposed insured:</p> <p>a. Been diagnosed as having AIDS or AIDS-related condition?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Received a positive result on an HIV test?..... <input type="checkbox"/> <input type="checkbox"/></p> | <p align="center">Yes No</p> | <p><b>22.</b> Within the past 12 months, has any proposed insured experienced or been treated by a physician for:</p> <p>a. Weight gain or loss of more than 12 pounds?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Recurrent episodes of Diarrhea?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Swollen or enlarged glands or lymph nodes?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Persistent cough, persistent or recurrent fever, 10 or more viral infections?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Chronic or recurrent skin rashes or lesions?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>23.</b> Within the past 5 years, has any proposed insured:</p> <p>a. Been hospital confined, had surgery, advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Had a heart, bone, or blood study, MRI, chest x-ray, 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><b>24.</b> Has any proposed insured ever been:</p> <p>a. Treated or counseled for alcohol or drug use or attended a drug or alcohol support group?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>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><b>25.</b> Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants, shunts, pacemakers or valve replacements or stents?.. <input type="checkbox"/> <input type="checkbox"/></p> <p><b>26.</b> Within the past 5 years, has any proposed insured (or presently have) a mental or physical impairment or deformity, or a congenital abnormality, disease or trait not previously disclosed?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>27.</b> Within the last six months, has any proposed insured taken any prescription medication or now taking prescription medication or receiving treatment of any kind for any condition not listed above?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>28. FOR FEMALE PROPOSED INSURED ONLY:</b><br/><b>(Questions 28. a-d)</b></p> <p>a. Any disorder or condition of the female reproductive organs, abnormal Pap Smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean Section Delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain or HPV (human papillomavirus)?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Date of last Pap Smear _____<br/>Results _____</p> <p>c. Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Breast disorder, disease, changes, condition or lump(s), aspiration(s), calcifications, biopsies including removal or placement of breast implants or mammoplasty?..... <input type="checkbox"/> <input type="checkbox"/></p> | <p align="center">Yes No</p> |
|---|------------------------------|--|------------------------------|

**COMPLETE THE FOLLOWING FOR EACH “YES” ANSWER TO QUESTIONS 20 THROUGH 28 ABOVE.**

Question Number	Name of Person	Date of Treatment		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
		From	To			

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

**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. | Are you the owner of an incorporated business?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Are you a sole proprietor or a partner in a partnership?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Are you an employee of a business?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|    | a. Will your employer pay a portion of your health insurance premium?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|    | b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|    | c. Will your 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)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Insurance Fraud** — Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

**APPLICATION DECLARATION & AGREEMENTS**

I, the undersigned proposed insured and spouse, if any, have personally completed this application and represent that the answers and statements in Sections I, II, III, and IV on this application are true, complete and correctly recorded and agree they will be used to determine my eligibility for coverage under the health insurance plan, indicated below (the "Plan"). I understand and agree that: 1) "Proposed Insured" means all persons named in questions 4 through 28; 2) all statements and answers in this application and in any supplements or amendments to it are complete and true; 3) I have inquired about and have personal knowledge of, the medical history of each Proposed Insured; 4) any incorrect or incomplete information on this application may result in loss of coverage or claim denial; 5) no insurance shall take effect unless the policy is issued (or this application is made to change an existing policy, unless the change is approved) and the policy is actually delivered to the Proposed Insured and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the plan.

I understand and agree that:

1. a future change in my employment status to an ineligible occupation may cause me to no longer be eligible for the Plan as of the date of coverage;
2. eligibility for the Plan does not constitute initial coverage under the Plan; and
3. initial coverage under the Plan is subject to the Company's underwriting criteria.

**ATTENTION PROPOSED INSURED:**

After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signed at \_\_\_\_\_ Date \_\_\_\_\_ Proposed Insured's Signature \_\_\_\_\_  
City State

Soliciting Agent (Please Print) \_\_\_\_\_ Spouse's Signature \_\_\_\_\_

**For Agent:** Each question on the application was completed by the proposed insured(s). I have personally witnessed/verified the reading, completion and signing of this application.  Yes  No

**I have/have not collected the premiums as stated on the front of this application and have not left the proposed insured a Conditional Receipt.**

Soliciting Agent Signature \_\_\_\_\_ Personal Code/Writing No. \_\_\_\_\_ Field Office \_\_\_\_\_

**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, 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 LIFE INSURANCE COMPANY OF TEXAS, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS 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 Life Insurance Company of Texas underwriters, claims 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 LIFE NSURANCE COMPANY of TEXAS 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 health 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 actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Signature of Primary Applicant or Representative\* \_\_\_\_\_

Applicant's Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse or Representative\* \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Address of Proposed Insured(s) \_\_\_\_\_

\*If the Applicant's Representative signs the Authorization, you must include the Authorized Representative's name, address, telephone number and relationship or capacity to the Applicant.

## RATING CLASSES

**Rating classes are determined on an individual basis - Each family member is evaluated individually. American National Life Insurance Company of Texas uses 4 rating classes:**

**Tobacco User:** This includes any applicant who has used tobacco products, including smokeless or chewing tobacco within the past 12 months prior to the application.

**Standard:** This includes applicants who have not used tobacco within 12 months preceding the application but are not eligible or do not qualify for the Preferred Rates.

**Substandard:** This includes applicants who would require an extra premium or exclusion waiver(s) for certain health conditions that are otherwise not insurable.

**Preferred:** To be eligible for the Preferred Rate Discount, the applicant must be 19 years or older and applying as a primary insured or spouse. Additionally, this class includes applicants who are generally healthy and lead a healthy lifestyle.

**If any of the following apply, preferred rates are not available:**

- ◆ **Medical Exclusions / Rider**
- ◆ **Special Class Rating**
- ◆ **Answers "Yes" to any of the questions in the Preferred Rating Questionnaire**

## PREFERRED RATING QUESTIONNAIRE

	APPLICANT		SPOUSE	
	Yes	No	Yes	No
1. Have you used tobacco in any form in the past 12 months prior to the application?				
2. Does your weight fall outside the standard weight range listed on the build chart provided in this forms packet or in the Field Underwriting Manual?				
3. Have you had blood pressure readings in excess of 140/95 and/or been treated for hypertension in the past 2 years?				
4. Have you had cholesterol readings in excess of 250 and/or been treated for elevated cholesterol or triglycerides in the past 2 years?				
5. Have you had any convictions for OUI, DUI, DWI or more than 3 moving violations in the past 12 months?				
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.)				
7. Have you recently applied for coverage and been turned down, rated, or offered modified coverage within the past 12 months?				

**Note:** The applicant 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.

\_\_\_\_\_  
Applicant Date

\_\_\_\_\_  
Spouse Date

\_\_\_\_\_  
Drivers license number State

\_\_\_\_\_  
Drivers license number State

\_\_\_\_\_  
Licensed Agent Date

\_\_\_\_\_  
Agent number

PLEASE SIGN THE STATEMENT BELOW AND RETURN IT TO YOUR AGENT

I, \_\_\_\_\_  
hereby acknowledge that I have received and read the material contained in this packet  
describing the rights of Eligible Individuals under HIPAA and understand its content.

\_\_\_\_\_  
Recipient's Signature

Date \_\_\_\_\_

Name of Agent \_\_\_\_\_

Form 4635A

## EMPLOYEE CENSUS FORM

For  
American National Life Insurance Company of Texas

Applicant Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip Code

Nature of Business: (Specific) \_\_\_\_\_

Type of Ownership:  Sole Proprietorship  Partnership  Corporation

Number of Employees: \_\_\_\_\_

The Employer understands and agrees:

1. Any premium refunds that may be due will be sent to the Applicant directly.
2. That it does not currently and will not in the future make any contribution to any portion of the Applicant's premium or fee payment or make any reimbursements for premium or fee payment to the Applicant through wage adjustment or other method, as evidenced by this Agreement, the ANL-3100 or the application.
3. That the Insurance applied for the Applicant is neither Intended nor anticipated to be an employer-sponsored health insurance plan, as defined by state and/or federal law;
4. That it does not currently and will not in the future, claim any tax benefit for the amounts remitted, such as but not limited to, Section 106, 125 or 162 of the Internal Revenue Code;

\_\_\_\_\_  
Signature of Employer/Authorized Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name of Employer/Authorized Representative

\_\_\_\_\_  
Date

**Note: This form required only if Applicant is submitting premium on an Incorporated check.**

ECM03

# Confirmation of Presentation

At my request, the agent whose signature appears below, visited me to determine my interest in applying for health insurance with American National Life Insurance Company of Texas. The agent informed me he was authorized to sell insurance for American National Life Insurance Company of Texas (the "Company"). The agent was courteous and fully explained to me all the provisions of the group insurance plan including benefits, exclusions, limitations, waiting periods, coordination of benefits and deductibles if any, and answered all my questions to my satisfaction.

Applicant and agent acknowledge that the agent asked each and every question on the enrollment application. The answers on the application are my truthful and complete answers with nothing left out that applicant in any way related or stated to the agent. I signed the application only after a full review of the questions and answers had been filled in. I, the applicant, fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to deny future claims, refuse coverage and to refund premiums as though the certificate had never been in force.

The agent informed me that the amount of the initial insurance premium and one time administrative fee which I have delivered to him will be held by the Company. The agent informed me that in the event coverage is not approved, the initial premium will be refunded to me.

In signing this form, I agree that I have carefully examined and understand the materials provided to me and the application, and that neither the agent nor the Company is bound by any knowledge or statements made by the agent or me, unless set forth in writing in the application and receipt.

**I acknowledge confirmation of presentation.**

**I understand that coverage is not effective unless and until approved as applied for by the Company.**

**This confirmation of presentation was provided along with a brief description of coverage which I received from the agent.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

FormANLConf

**Height/Weight Guide  
For Use With Determining Preferred Rating Eligibility**

<b>Height</b>	<b>Adult Male Normal Weight</b>	<b>Adult Female Normal Weight</b>
4'10"	-	90-148
4'11"	-	92-151
5'0"	-	94-154
5'1"	105-183	97-157
5'2"	106-186	97-160
5'3"	109-190	99-163
5'4"	112-196	102-168
5'5"	115-202	105-170
5'6"	118-207	108-173
5'7"	122-213	111-177
5'8"	126-220	115-182
5'9"	130-227	118-186
5'10"	134-230	122-193
5'11"	138-236	125-198
6'0"	142-240	129-210
6'1"	147-248	135-222
6'2"	153-253	141-234
6'3"	158-261	-
6'4"	163-269	-
6'5"	170-277	-
6'6"	178-286	-
6'7"	187-295	-
6'8"	196-304	-

# What You Should Know About HIPAA From The American National Family Of Companies

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

### What is HIPAA ?

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

### Do I qualify for guaranteed access to health insurance?

If all of the following statements apply to you, you are an Eligible Individual under HIPAA and you qualify for guaranteed access. As of the date on which you apply for coverage:

1. You have had prior creditable coverage for a period in the aggregate of 18 or more months and your most recent prior Creditable Coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);
2. You are not eligible for coverage under a group health plan, part A or part B of Medicare, or Medicaid (or any successor program) and do not have other health insurance coverage;
3. Your most recent coverage within the coverage period described in paragraph (1), above, was not terminated based on nonpayment of premiums or fraud;
4. You were offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, and you elected such coverage and have exhausted such continuation coverage under such provision or program.

### What is Creditable Coverage?

Creditable Coverage means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Medicare.
4. Medicaid.
5. Health insurance plans for members of the U.S. Armed Forces and their dependents.
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A State health benefits risk pool.
8. Health insurance plans for employees of the U.S. Government and their dependents.
9. A public health plan (as defined in regulations).
10. A health benefit plan under section 5(e) of the Peace Corps Act (22-2504(e)).

A period of Creditable Coverage shall not be counted if there was more than a 62-day period during all of which the individual was not covered under any Creditable Coverage.

### What is an Eligible Individual ?

Eligible Individuals are the only people who have guaranteed access to health insurance under HIPAA. HIPAA requires health insurance carriers to allow guaranteed access to certain plans, at the carrier's election (Federal Fallback), unless a state adopts an Alternative Mechanism. Under HIPAA, Alternative Mechanisms include high risk pools, guaranteed issue requirements for one or more plans and other methods to assure the access requirements of HIPAA are followed.

### What *alternative mechanism* did my state adopt?

Your American National agent can tell you specifically, but generally states have created risk pools or adopted Federal Fallback positions. In states which have adopted risk pools as an Eligible Individual you have 62 days (Eligibility Period) from the date your last employer-sponsored coverage terminated to obtain coverage through the pool. **IF YOU FAIL TO MAKE APPLICATION TO THE POOL IN THE REQUIRED TIME PERIOD, THE POOL DOES NOT HAVE TO PROVIDE COVERAGE.** If you have exhausted any portion of your Eligibility Period, you should strongly consider making application directly to the pool. You may apply to American National in the interim, but you will NOT have guaranteed access and will be subject to full underwriting and other limitations provided under the policy.

If your state is a Federal Fallback state, American National is required to provide you guaranteed access to health insurance through one of two policy forms at your election. Your American National agent can give you information on each form. **GUARANTEED ACCESS TO THESE PLANS IS ONLY AVAILABLE IF YOU ARE AN ELIGIBLE INDIVIDUAL AND YOU MAKE APPLICATION IN THE 62 DAY PERIOD DESCRIBED ABOVE.**

**Form 4635 Rev 4/98 GRP 0189**



**American National Life Insurance Company of Texas**

One Moody Plaza, Galveston, Texas 77550

[www.anico.com](http://www.anico.com)

**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS  
(HEREIN REFERRED TO AS ANTEX)  
HOME OFFICE-ONE MOODY PLAZA  
GALVESTON, TEXAS 77550**

**CATASTROPHIC HOSPITAL INSURANCE COVERAGE  
PREFERRED PROVIDER COMPONENT, WHEN SELECTED  
OUTLINE OF COVERAGE  
POLICY ANL-C06KS  
KANSAS**

**NOTICE:** The Policy is available with a PPO component upon request. Failure to comply with the PPO requirements will result in a reduction of benefits otherwise payable.

- (1) **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and ANTEX. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- (2) This coverage is designed to provide You with coverage for limited hospital, medical and surgical expenses which You incur as the result of a covered Injury Sickness. Coverage is provided for the benefits outlined under Medical Services. The benefits described below may be limited by the **EXCEPTIONS** and **LIMITATIONS.**
- (3) **BENEFITS** – The Policy provides catastrophic medical expense coverage . Coverage is provided for the Eligible Expenses that are listed in this Outline of Coverage and the Policy. Eligible Expenses may be limited by the **EXCEPTIONS**, listed in this Outline of Coverage and the Policy.

Any covered charge for Eligible Expenses will be limited to the Reasonable and Customary Charge for services rendered or supplies furnished and must be Medically Necessary for the diagnosis and treatment of a covered Injury or Sickness. Calculations are made separately for each Covered Person on a Calendar Year basis.

Basic benefits payable under the Policy are calculated as  $(a-b) \times c$ , where:

- (a) Represents Eligible Expenses.
- (b) Represents the Deductible Amount.
- (c) Represents the Coinsurance Amount\*.

Once the Stop Loss Amount is met, We pay Eligible Expenses at 100% for the remainder of the Calendar Year.

\*When a Covered Person is admitted to an Out-of-Network Hospital, uses an Out-of-Network Same Day Surgery Facility, or receives treatment from an Out-of-Network Doctor; the Company pays benefits at the Out-of-Network Coinsurance Amount, which is lower than the In-Network Coinsurance Amount. In order to receive the maximum benefit payable, charges must be received In-Network. However, In the event of an Emergency, Out-of-Network charges are considered In-Network and payable at the In-Network Coinsurance Amount.

**(4) ELIGIBLE EXPENSES**

The Policy covers the Eligible Expenses listed below. We apply these Eligible Expenses separately for each Covered Person. In order for ANTEX to pay benefits, an Eligible Expense must meet these three conditions:

1. The Eligible Expense must be provided for a Covered Person while the Policy is in force for such person;
2. The Eligible Expense must not be excluded under the **EXCEPTIONS** section; and
3. The Eligible Expense must be Medically Necessary and appropriate for the diagnosis or treatment of a covered Injury or Sickness and prescribed by a Doctor.

An expense is “incurred” on the date a provider or facility performs the service or furnishes the supplies.

This section lists the Eligible Expenses. We first apply Eligible Expenses to the Cash Deductible Amount. If the selected Coinsurance Amount is less than 100%, We will pay the remaining Eligible Expenses, which are in excess of the Cash Deductible Amount, at the Co-Insurance Amount up to the Stop Loss Amount. Benefits paid for Eligible Expenses in excess of the Stop Loss Amount are paid at 100% for the remainder of the Calendar Year. All benefits payable under the Policy are subject to the **POLICY MAXIMUM FOR EACH INJURY OR SICKNESS** and the **POLICY MAXIMUM FOR ALL INJURIES AND SICKNESSES**, each shown in the Policy Schedule.

The following are Eligible Expenses under the Policy:

**Hospital Stay** - Reasonable and Customary Charges made by the Hospital for each day a Covered Person is Hospital Confined. Such charges will include:

1. Room accommodations (up to the average semi-private room rate). The average semi-private room rate includes any separate charges such as room, nursing services, maintenance, utilities and similar items. If a Hospital has only private rooms, Eligible Expenses will be limited to 90% of the private room charge.
2. Charges for an Intensive Care Unit, Coronary Care Unit and Neonatal Intensive Care Unit confinement up to three times the average semi-private room rate.
3. Hospital charges for miscellaneous medical services and supplies that are necessary for the treatment of the Covered Person while Hospital Confined. These charges include: operating room, recovery room, anesthesia, surgical dressings, central supplies, casts and splints, Medicines or Drugs, x-ray photographs, laboratory service and oxygen, equipment and services, blood plasma, whole blood and blood derivatives.

All charges must be incurred while a Covered Person is Hospital Confined.

Eligible Expenses **DO NOT** include: charges for take-home Medicines or Drugs (unless otherwise specifically provided by the Policy), personal and convenience items, or items that are not intended primarily for use while Hospital Confined.

**Surgery** - Reasonable and Customary Charges by a Doctor for the primary surgery performed on a Covered Person while Hospital Confined or in a Same Day Surgery Facility. This benefit includes routine care after the surgery.

We will pay other surgical procedures, done during this same session, at 50% of the Reasonable and Customary allowance.

A surgical procedure involving TMJ (Temporomandibular Joint Disorder) is limited to a Lifetime Maximum of \$2,500 per Covered Person.

**Assistant Surgeon** – Reasonable and Customary Charges for surgical assistance performed on a Covered Person while hospital confined or in a Same Day Surgery Facility. Eligible Assistant Surgeon expense is limited to 25% of the Eligible Expense allowance for the primary surgeon, when the assistance is rendered by a Doctor. This benefit reduces to 20%, when a Physician Assistant assists and to 15% if the assistance is by a Registered Nurse.

**Second Surgical Opinion** - Reasonable and Customary Charges for a Doctor providing a second surgical opinion regarding the advisability of surgery. If the initial and second surgical opinions conflict, We will pay benefits for a third surgical opinion. We do not subject charges for a second and third opinion to the Cash Deductible Amount.

**Anesthesia Administration** - Reasonable and Customary Charges by an anesthesiologist for the administration of anesthesia to a Covered Person who is undergoing surgery while Hospital Confined or in a Same Day Surgery Facility.

The anesthesiologist must be at the operation solely to render the anesthesia service. We will reduce eligible benefits by 50% if a nurse anesthetist, operating surgeon or assistant surgeon administers the anesthesia and any incidental fluids as part of a covered surgical procedure.

Charges include administration of anesthesia to a Covered Person undergoing surgery in a Doctor's office, clinic, or Hospital Emergency room or urgent care facility. This includes charges for the reasonable cost of hospitalization and general anesthesia in order for a Covered Person to safely receive dental care if he or she is under 8 years of age or is developmentally disabled. This benefit does not apply to treatment rendered for temporomandibular joint disorders (TMJ).

**Doctor Visits** - Reasonable and Customary Charges by the primary attending Doctor for one visit per day while Hospital Confined.

**Pathology** - Reasonable and Customary Charges by a pathologist for the interpretation of diagnostic tests or studies while Hospital Confined or in a Same Day Surgery Facility.

**Physiotherapy** - Reasonable and Customary Charges for physical, speech or inhalation therapist services while Hospital Confined or in a Same Day Surgery Facility.

**Post Confinement Therapy** - Reasonable and Customary charges that a Hospital, or Hospital-based clinic, bills for Post Confinement Therapy provided to a Covered Person who is not Hospital Confined. The Covered Person must require such Therapy for a Sickness or Injury that caused a covered Hospital Stay. The following types of Therapy are eligible under this provision: Radiation therapy, including treatment planning; Chemotherapy, including treatment planning; Physical therapy; Speech therapy; and Occupational therapy.

**Radiology** - Reasonable and Customary Charges by a radiologist for the interpretation of diagnostic tests or studies while Hospital Confined or in a Same Day Surgery Facility.

**Same Day Surgery Facility** - Reasonable and Customary Charges for care received in a Same Day Surgery Facility. Eligible Expenses will be the fees for the use of the facility and other miscellaneous charges made by the facility. If the Covered Person stays in the Ambulatory Surgical Center for 18 or more hours, We will pay Eligible Expenses up to the average semi-private room rate for the use of the facility. The semi-private room rate will be consistent with Hospital charges in the area where the Ambulatory Surgical Center is located.

## **Organ Transplants**

**Your Policy Schedule shows the Maximum Benefit for Organ Transplants per Covered Person.**

The organ being transplanted must be the organ of primary disease and must be one of the following organs:

1. Heart;
2. Lung;
3. Liver;
4. Cornea;
5. Pancreas;
6. Kidney; or
7. Bone Marrow and/or stem cells harvested from bone marrow or peripheral blood. (Stem cell or bone marrow transplants do not have to be the organ of primary disease).

We will pay benefits for the Eligible Expenses that result from charges related to, caused by, contributed to or resulting from an Organ Transplant. The Covered Person must incur the charges during the Transplant Period. We will not pay for charges the Covered Person incurs outside the Transplant Period, except for anti-rejection Drug charges.

We will pay donor benefits:

1. Up to \$15,000 in Eligible Expenses; and
2. When You or a Covered Person is legally responsible for the charges.

**Transplant Centers** - We have contracted with certain specified transplant centers to provide Organ Transplants at a negotiated rate. If a Covered Person utilizes a specified transplant center, We will waive the \$1,000,000 Maximum Benefit for an Organ Transplant and the charges will instead be applied towards the Policy Maximum. All other provisions of the Policy will continue to apply.

You or a Covered Person may send a written request to Our Case Management Department for a copy of the maximums.

**Hospice Care Benefit** - Reasonable and Customary Charges for Hospice Care provided by a Hospice agency up to the Maximum Benefit for Hospice Care shown in the Policy Schedule. We will not pay benefits under this provision and under another benefit provision of the Policy. We only pay benefits for Hospice Care when:

1. The Hospice Care is provided to reduce or abate pain and not for cure; and
2. The Covered Person's Doctor certifies that the Covered Person's life expectancy is less than six months.

**Home Health Care** - Reasonable and Customary Charges for Home Health Care up to \$40 per visit. There is a limit of one visit per day and 60 Home Health Care visits in each Calendar Year. We count the following as one Home Health Care Visit:

1. When a Home Health Care provider visits the home to evaluate the need for developing a Home Health Care plan; or
2. Up to four consecutive hours of Home Health Care.

The Home Health Care must begin within 7 days of a prior Hospital Stay of at least 3 days. The Home Health Care must be provided in lieu of a Hospital Stay. The Home Health Care must be for treatment of the same Sickness or Injury for which the Covered Person was Hospital Confined.

Home Health Care includes the following Eligible Expenses:

1. Registered Professional Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) services/supplies;
2. Qualified physiotherapist, speech therapist or inhalation therapist services/supplies;
3. Medical social services worker services/supplies. The services/supplies must be Medically Necessary to understand the emotional, social and environmental factors affecting the Covered Person's Sickness;
4. Home health aide services/supplies when under a R.N.'s direct supervision;
5. Nutritional guidance when Medically Necessary;
6. Oxygen and its administration.

**Alcoholism, Mental Condition Treatment** – Reasonable and Customary Charges for 30 days inpatient treatment per Calendar Year for a Covered Person confined for treatment of alcoholism, drug abuse or Mental or Nervous Conditions in a medical care facility licensed for such care.

Reasonable and Customary Charges for the outpatient treatment of alcoholism, drug abuse or Mental or Nervous Conditions in a medical facility when confinement is not necessary for the treatment or by a Doctor licensed or psychologist licensed to practice under Kansas law. Eligible Expenses will be considered for payment on the same level as they are provided for a medical condition, subject to the following yearly and Lifetime Maximums: (a) 100% of the first \$100; (b) 80% of the second \$100 in a Calendar Year; and (c) 50% of the next \$1,640 in a Calendar Year. The Lifetime Maximum Benefit for outpatient treatment is \$7,500 per Covered Person.

**Mammogram and Pap Smear** - Reasonable and Customary Charges for mammograms or pap smears when performed at the direction of a of a person licensed to practice medicine and surgery by the Board of Healing Arts within the lawful scope of such person's license, including services performed at a mobile facility certified by the Federal Health Care Financing Administration and performing mammography testing by American Cancer Society guidelines.

**Childhood Immunizations** – Reasonable and Customary Charges for Covered Persons under the age of six for at least five doses of vaccine against diphtheria; pertussis; tetanus; at least four doses of vaccine against polio, Haemophilus B (Hib); and three doses against hepatitis B; two doses of vaccine against measles, mumps, rubella; one dose of vaccine against varicella, and other vaccines as may be prescribed by the Kansas Secretary of Health and Environment. The required benefits shall apply to immunizations administered to each newly born child from birth to 72 months of age. Benefits under this provision are not subject to the Policy's Deductible Amount or Coinsurance Amount.

**Osteoporosis** – Reasonable and Customary Charges for the Medically Necessary diagnosis, treatment and management of osteoporosis. Coverage is provided for a Covered Person with a condition or medical history for which bone mass measurement is Medically Necessary. A health care professional who is licensed to practice medicine and surgery must deliver the services.

**Diabetes** – Reasonable and Customary Charges for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes. Coverage includes equipment and supplies, limited to hypodermic needles and supplies, used exclusively with diabetes management. Insulin is only covered when administered while a person is Hospital Confined.

Reasonable and Customary Charges for self-management training and education, including medical nutrition therapy, while Hospital Confined and if prescribed by a health care professional legally authorized to prescribe such services and supplies under the law.

Diabetes self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. A health care professional, legally authorized to prescribe such services, must have ordered the training. The Covered Person must be treated at a program approved by the American Diabetes Association by a person certified

by the national certification board for diabetes educators. As to nutritional education, the Covered Person must be treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

**Prostate Screening** – Reasonable and Customary Charges for a prostate screening for men 40 years of age or over who are symptomatic or in a high risk category and for all men 50 years of age or older. “Prostate screening” consists of a prostate-specific antigen blood test and a digital rectal exam.

**Professional Ambulance Service**–Reasonable and Customary Charges for transportation to the nearest Hospital qualified to treat Injuries or medical Emergencies.

**Complications of Pregnancy**

If a Covered Person suffers Complications of Pregnancy while covered under the Policy, Eligible Expenses incurred for treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness. If an expense does not result solely from the treatment of the Complications of Pregnancy, then it will be deemed due to normal pregnancy and not covered under the Policy unless the optional Maternity As Any Other Sickness Rider is attached to the Policy.

**Foreign Emergency Treatment**

We will pay for benefits for Eligible Expenses resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the Eligible Expenses that We would have paid if the Covered Person had received the Emergency treatment where the Covered Person resides.

**Optional Riders**

The following Optional Riders are available for additional premium. This is a summary of the Riders only. Please refer to the Riders for details, including exceptions and limitations.<sup>1</sup>

- **Optional PPO Rider, ANL-PPR06KS – (Premium: \_\_\_\_\_)**

This Rider reduces the cost of the base coverage by having an agreement with a PPO to provide medical care or services at a negotiated rate. The Company names the PPO that You and other Covered Persons may use. A PPO may include Doctors, Hospitals, Ambulatory Surgery Facilities and other types of medical facilities. Voluntary use of an out-of-network provider results in the Company reimbursing Eligible Expenses at an “Out-of-Network” Coinsurance, which is less than the “In-Network” Coinsurance. Eligible Expenses incurred in the event of an Emergency are payable as In-Network expenses. The Coinsurance Amounts are listed on the Policy Schedule.

- **Optional Outpatient Accident Expense Benefit Rider, ANL-ACCEX06KS – (Premium: \_\_\_\_\_)**

This Rider reimburses Eligible Expenses resulting from the Medically Necessary treatment of a covered Injury on an Outpatient basis. Eligible Expenses are limited to Your selection of the **MAXIMUM BENEFIT PER INJURY** of \$400; \$800; or \$1,200, which is listed on the Policy Schedule.

- **Optional Outpatient Doctor Rider, ANL-OPB06KS – (Premium: \_\_\_\_\_)**

This Rider reimburses charges for Outpatient Eligible Expenses that are listed in the Rider. These Eligible Expenses include, but are not limited to, Outpatient doctor charges. Benefits are reimbursed once Eligible Expenses exceed the Rider’s \$1,000 Calendar Year Cash Deductible Amount. The Rider then pays 80% of the Reasonable and Customary Charges, up to the \$10,000 **OUTPATIENT DOCTOR RIDER MAXIMUM BENEFIT PER CALENDAR YEAR**. The Deductible, Coinsurance and Maximum Benefit are listed on the Policy Schedule.

- **Optional Maternity As Any Other Sickness Rider, ANL-KSMAT2003 – (Premium: \_\_\_\_\_)**

This Rider covers normal pregnancy and childbirth as any other Sickness is payable under the Policy. The Insured must become pregnant while covered under the Rider.

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<sup>1</sup> “Outpatient” means not Hospital Confined.  
Form ANL-C06KSOC

• **Optional Outpatient Prescription Drug Rider, ANL-PDR06KS – (Premium: \_\_\_\_\_)**

After You meet the Your selected Deductible Amount and Prescription Drug Copayment, this Rider reimburses Eligible Expenses for covered Outpatient Prescription Drugs, at the selected Coinsurance Amount. The Deductible Amount and Copayments are listed on the Policy Schedule.

<b>PARTICIPATING PHARMACY</b>		<b>NON-PARTICIPATING PHARMACY</b>	
Calendar Year Deductible, Individual Plan:	\$500 or \$1,000	Calendar Year Deductible, Individual Plan:	\$1,000 or \$2,000
Calendar Year Deductible, Family Plan:	\$1,000 or \$2,000	Calendar Year Deductible, Family Plan:	\$2,000 or \$4,000
Copay, Generic:	\$10	Copay, Generic:	\$10
Copay, Brand Name:	\$25	Copay, Brand Name:	\$25
Copay, Mail Order Generic:	\$30	<b>Mail Order not available</b>	<b>Mail Order not available</b>
Copay, Mail Order Brand Name:	\$75	<b>Mail Order not available</b>	<b>Mail Order not available</b>

**(5) EXCEPTIONS**

**WE DO NOT COVER AN INJURY OR SICKNESS THAT WE HAVE EXCLUDED BY NAME OR DESCRIPTION.**

**THE POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO OR RESULTING FROM:**

1. Injury or Sickness if the loss is covered under these or similar laws: Employer’s Liability Law or Occupational Disease Law. Benefits are not provided for Injury or Sickness related to Your job to the extent You are covered or are required to be covered by the Workers’ Compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers’ Compensation law, the Policy will not pay those medical benefits that would have been payable in absence of that settlement.
2. Injury or Sickness that results from war or an act of war, whether war is declared or not.
3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs. However, We will not apply this Exception if:
  - (a) The Covered Person receives a charge that he has to pay by law; and
  - (b) The Hospital or facility would have made the charge even if no insurance existed.
4. Eligible Expenses resulting from procedures or treatments that are Experimental or Investigational Medicine.
5. Organ Transplants, except as otherwise provided under the section titled Organ Transplants.
6. Pregnancy and childbirth, except for Complications of Pregnancy. This Exception does not apply if the Optional Maternity As Any Other Sickness Rider is attached to the Policy.
7. Mental or Nervous Disorders, except as provided by the Policy.
8. Plastic, cosmetic or reconstructive surgery. This Exception includes breast reduction and surgery to repair, replace or remove breast implants. This Exception does not apply when surgery is required:
  - (a) To correct damage for a covered Injury or Sickness;
  - (b) To repair a birth defect of a child born to You and continuously covered under the Policy from its birth; or
  - (c) For reconstructive surgery following a covered mastectomy.
9. Dental Treatment unless due to Injury to a Covered Person’s natural teeth.
10. Eligible Expenses for a Pre-Existing Condition for the first 12 months of coverage.

11. Any attempt at suicide or any intentionally self-inflicted Injury.
12. A Covered Person's commission of or attempt to commit a felony, or an illegal act or being engaged in an illegal occupation.
13. Charges for, or relating to, any loss that results from:
  - (a) A Covered Person, voluntarily or involuntarily, administering, taking or injecting any drug, sedative or narcotic unless taken as a Doctor prescribes; or
  - (b) Injuries to a Covered Person while the person was operating a motor vehicle and his blood alcohol content exceeded 0.08% by weight, whether or not the Covered Person's use of alcohol causes or contributes to the Injury.
14. Charges relating to radial keratotomy, laser surgery, or any type of surgery or procedure, for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.
15. Charges relating to treatment of obesity, including exogenous, endogenous, morbid obesity, or weight reduction.
16. Mandibular or maxillofacial surgery to:
  - (a) Correct growth defects;
  - (b) Correct jaw disproportions or malocclusions;
  - (c) Increase vertical dimension; or
  - (d) Reconstruct occlusion after one year from a child's date of birth or a child's date of adoption.

We do not apply this Exception for the repair of a congenital anomaly or birth defect of a child born to You or a child that You adopt. The Policy must continuously cover the child from birth, adoption or placement for adoption.

17. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.
18. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; transsexual surgery.
19. Sclerotherapy for veins of the extremities or laser surgery to minimize veins.
20. Care received in a Rehabilitation Facility, including services of this type rendered in a separate section of a building that houses an Acute Care Facility.
21. Routine newborn care, unless otherwise stated in the Policy.
22. Care in a nursing home, custodial institution or domiciliary care or rest cures.
23. Eligible Expenses that You or a Covered Person is not legally obligated to pay.
24. Benefits that Medicare pays.
25. Charges for which benefits are not specifically provided in the Policy.
26. Medicines or Drugs, treatment or procedure that either promotes or prevents contraception or prevents childbirth including and relating to, but not limited to: (a) artificial insemination; (b) in-vitro fertilization or any other diagnosis or treatment for the control, promotion or enhancement of fertility; (c) treatment for impotency, including Viagra; (d) sterilization or reversal of prior sterilization; or (e) elective or non-Medically Necessary and therapeutic abortion, including the Drug RU-486, unless the life of the mother would be endangered if the fetus were carried to term.
27. Medicines or Drugs or medicinal supplies when a Covered Person is not Hospital Confined.

## LIMITATIONS

1. After coverage has been in effect under the Policy for two years, ANTEX may reduce or deny a claim or void coverage if You or a Covered Person has made a misstatement in the application for coverage.
2. Until coverage has been in effect for 12 months, ANTEX may reduce or deny a claim if a disease or physical condition existed 12 months prior to the Policy Date.
3. ANTEX may deny a claim of void coverage at any time if You or a Covered Person made a fraudulent material misrepresentation in the application for coverage under the Policy.
4. ANTEX may deny a claim if a Covered Person is hospitalized or receives treatment for a disease or physical condition that has been excluded from coverage by rider.

**PRE-EXISTING CONDITIONS** means physical or mental conditions, not disclosed on the Application, and:

1. For which medical advice, testing, care, treatment or medication was received within 12 months before the Policy Date;
2. That produced symptoms, within 12 months prior to the Policy Date, that would have allowed a Doctor to make a diagnosis of the condition producing the symptoms; or
3. That would have caused a Prudent Layperson to seek medical diagnosis or treatment within the 12 months prior to the Policy Date.

A pregnancy that exists on the Policy Date is a Pre-Existing Condition.

We do not cover Pre-Existing Conditions during the first 12 months of coverage.

**(6) RENEWAL PROVISION** – ANTEX can refuse to renew the Policy as of any renewal premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of the Policy or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy;
3. You no longer reside, live or work in the PPO service area or in an area where We have authority to do business. We will only apply this provision if We end coverage uniformly and without regard to any health-status related factor of a Covered Person (applicable only to the PPO plan); or
4. We are ceasing to offer individual policies providing hospital, medical or surgical expense benefits.

If We refuse to renew coverage under reason numbers 1-3 above, We will give You 30 days notice prior to the non-renewal effective date. If We refuse to renew policies of this type under reason number 4 above, We will give You 90 days notice prior to the non-renewal effective date. We will also give You the option to purchase any other individual health insurance coverage that We are then currently offering. If We discontinue offering all health insurance coverage in this market, We will give You 180 days notice prior to the discontinuance.

At the time of coverage renewal, We may modify Policy coverage. However, the modification must be consistent with State law and effective on a uniform basis among all individuals that We cover under the Policy. Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

The Policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. This grace period will not apply if ANTEX has notified You, at least 30 days before the premium due date, in writing of its intent not to renew the Policy.

## **(7) CANCELLATION BY INSURED**

You may cancel the Policy at any time by written notice delivered or mailed to ANTEX, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or Your death, ANTEX will promptly return the unearned portion of any premium paid. The earned premium shall be computed by using the short-rate table last filed with the state official having supervision of insurance in the state where You resided when the Policy was issued. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

(8) Initial Annual Premium: \$ \_\_\_\_\_  
Mode of Payment Selected: \$ \_\_\_\_\_  
Initial Modal Premium: \$ \_\_\_\_\_

**Premiums are subject to change.**

The Policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. This grace period will not apply if ANTEX has notified You, at least 30 days before the premium due date, in writing of its intent not to renew the Policy.

**(9) NOTICE**

The following information is available upon request:

1. A complete description of the health care services, items and other benefits that Your health plan covers or offers (provided in the Policy and this Outline of Coverage).
2. A description of any limitations, exceptions, or exclusions to coverage in Your health plan. This includes prior authorization policies, or other provisions that restrict access to covered services or items.
3. A listing of the health plan's participating providers, their business addresses and telephone numbers, the availability of those providers, and any limitations on Your choice of a provider.
4. Notification in advance of any changes in Your health plan that either reduces the coverage or benefits, or increases the cost, to You.
5. A description of the grievance and appeal procedures available under the health plan and Your rights regarding termination, non-renewal or cancellation of coverage. (The Policy describes termination, non-renewal or cancellation of coverage).

**THIS OUTLINE IS A BRIEF DESCRIPTION OF THE POLICY TERMS AND PROVISIONS.  
REFER TO THE POLICY FOR FURTHER DETAILS.**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Name (printed) of Licensed Resident Agent**

\_\_\_\_\_  
**Signature of Licensed Registered Agent**