



# Generations

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

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**Individually Underwritten Association Group  
Exclusively for NCAA Members and Their Families**

ANL-CAT(08)WV Forms Packet



## **Fair Credit Reporting Act (FCRA) Pre-Notification**

Federal and state law requires 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. No information collected concerning the sexual orientation of the Proposed Insured will be used to determine his or her eligibility for insurance.

## **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](http://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.



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. Has any Proposed Insured applying been covered under a health insurance plan including COBRA within the last 18 months?  Yes  No.  
 a. Will requested coverage replace or change any existing medical insurance?  Yes  No  
 b. If Yes, give plan details below and provide reason for replacement such as carrier terminated coverage or lower rates, etc.  
 c. **You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from ANTEX. If accepted, do you agree to discontinue your current medical insurance?**  Yes  No

Question#	Name of Company & Policy #	Plan Type Grp. or Ind.	Medical Insurance	Reason For Termination	Effective Date Month-Year	Termination Date Month-Year

12. Is any Proposed Insured applying for coverage under the federal HIPAA Program?  Yes  No If "Yes", please submit a letter of Creditable Coverage with the Enrollment Application.

13. 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)

14. 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)

15. 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.)

16. 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)

17. 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>18. 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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> <p>e. A nervous disorder, seizures, tremors, headaches, paralysis, palsy or injury of the brain, spinal cord, or nerves;..... <input type="checkbox"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> <p>k. Cancer in any form, tumor, cyst, polyp, or growth of any kind;..... <input type="checkbox"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> <p>m. A skin or subcutaneous tissue disorder, for example, burns, scars or hemangioma;..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>n. HIV, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC);..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>o. Mental or physical impairment or deformity; or congenital abnormality, mental retardation, developmental delay; or trait not previously disclosed;..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>p. For Male Proposed Insureds Only: ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>A male reproductive disorder, for example, disorder of the prostate, testicles, elevated PSA, or a sexually transmitted disease;..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>q. For Female Proposed Insureds (18+) Only... <input type="checkbox"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> <p>ii. Date of last Pap Smear _____<br/>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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> <p>19. 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"/> Yes <input type="checkbox"/> No</p> <p>20. Within the past 5 years, has any Proposed Insured:</p> <p>a. Had surgery, been hospital confined, or advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery; or..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> <p>21. 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"/> Yes <input type="checkbox"/> No</p> <p>22. 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; or..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption; or..... <input type="checkbox"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> <p>23. 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"/> Yes <input type="checkbox"/> No</p> |
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**COMPLETE THE FOLLOWING FOR EACH “YES” ANSWER TO QUESTIONS 18 THROUGH 23 ABOVE.**

Question Number	Name of Person	Date of Treatment From	Date of Treatment 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 Enrollment Application.

## APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by ANTEX and the Certificate or requested change is delivered to the Applicant, 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 for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate and understand its content.

**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 is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to ANTEX's underwriting criteria.

### Attention Applicant:

After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded.

I agree that my electronic signature on this Enrollment Application serves as my original signature.

Signed at \_\_\_\_\_ Date \_\_\_\_\_

City

State

Zip

Applicant's Signature \_\_\_\_\_ Spouse's Signature \_\_\_\_\_

Agent Name \_\_\_\_\_ Code/Writing# \_\_\_\_\_

Fax# \_\_\_\_\_ Email \_\_\_\_\_

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, MIB, Inc., 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 behalf of 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 Proposed Insured(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 compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I agree that my electronic signature serves as my original signature.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL LIFE INSURANCE 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 those 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.*

Proposed Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature (if coverage is requested for spouse) \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other \_\_\_\_\_ (Circle One).

## 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 \_\_\_\_\_

# NCAA



**Yes, I want to be a member of NCAA!**

National Consumer's Advantage Association  
16467 Wild Horse Creek Road, Chesterfield, MO 63017

*Please Choose One:*

- Silver Level (\$4.00 per month or \$48 annually)  
 Gold Level (\$6.00 per month or \$72 annually)

Under Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to National Consumer's Advantage Association, I appoint its President as my proxy irrevocably to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend.

Signed \_\_\_\_\_

Print Name \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

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

**Dues will be included in your regular premium notices or  
drafted from your account, if you elect the automatic bank draft option.**

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

\_\_\_\_\_  
\_\_\_\_\_

