Quality Health Insurance That Fits Your Budget

Major Med *Light*

Generic Forms Packet

Individually Underwritten Association Group Major Medical Coverage Exclusively for NCAA Members and their Families

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 non-profit 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

NCAA

National Consumer's Advantage Association
16467 Chesterfield Airport Road **Chesterfield, MO 63017**

☑ Yes, I want to be a member of NCAA!

Please Choose One:

- ❑ **Silver Level ($2.50 per month or $30 annually)**
- ❑ **Gold Level ($4.50 per month or $54 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.

Form NCAAAP

Height/Weight Guide
For Use With Determining Preferred Rating Eligibility

Height	Adult Male Normal Weight	Adult Female Normal Weight
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	-

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 preceeding 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. This allows full coverage for the health condition(s). Medical waivers are available for applicants with certain 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 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**

Drivers license number **State**

Licensed Agent **Date**

Spouse **Date**

Drivers license number **State**

Agent number

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

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

SECTION I — ELIGIBILITY ***(Submit a copy of your quote sheet with this application) (Quote Premium at Age Last Birthday.)***

Home Office Use

1. I, as an association member, apply for:

❑Plan: ANL-2003

Deductible Amount:
❑ $1,000 ❑ $1,500
❑ $2,000 ❑ $2,500
❑ $5,000

Out-of-Pocket Limit (not including deductibles):
❑ $1,250 Individual Out-of-Pocket Limit
❑ $2,500 Individual Out-of-Pocket Limit

Lifetime Maximum:
❑ $3,000,000
❑ $7,000,000

Optional Rider

Outpatient Prescription Drug Rider:
❑ Yes ❑ No
❑ $500 Deductible
❑ $1,000 Deductible

2. Special Requests

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.)

Amount collected with Application:
$ _____

Name and Address of Premium Payor if other than Applicant _____

TO BE COMPLETED PERSONALLY BY THE APPLICANT AND SPOUSE, IF ANY.

4. Proposed Insured Information

Proposed Insured(s) (Print Last Name, First Name, MI.)	Relationship	Marital Status Single	Married	Sex	Age	Date of Birth Mo.	Day	Year	State	Build Height	Weight	Social Security #
1	Applicant	❑	❑									
2	Spouse	❑	❑									
3												
4												
5												

5. Address (Permanent U.S. residence of primary insured.)
Number and Street or R.F.D.
_____
City State Zip

Phone: Hm( ) _____ Best time to call: ❑A.M. ❑P.M.
Work ( ) _____ ❑A.M. ❑P.M.
E-mail Address:

6. Employment Data	Employed Full-Time?	Name of Employer	Duties/Title	Avg. Monthly Earnings Last 12 Months
Person No. 1	❑Yes ❑No			$
Person No. 2	❑Yes ❑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 who 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.)

Section II — Other Insurance

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. Is any proposed insured currently covered by Medicare or Medicaid? ❑Yes ❑No

C. Has any proposed insured been covered under a health insurance plan including COBRA within the last 18 months? ❑Yes ❑No

D. 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

E. Has any proposed insured ever been covered by, or made application to, American National for other insurance coverage? ❑Yes ❑No

Complete the following for each "Yes" answer to questions 12A-E 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. 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. Has any proposed insured made claim or received benefits for any injury or sickness in the last 12 months or presently receive any government aid such as Medicaid, Medicare or SSDI? ❑ Yes ❑No (If "Yes", state whom, name of insurer, month, year and nature of ailment.)_____

Section III — *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 #)_____

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 APPLICANTS

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.

	Yes	No
20. Within the last 10 years has any proposed insured had any indication of, diagnosis of, or treatment for:		
a. The lungs or respiratory system, including hayfever, allergies, including desensitization, sinus infections, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, emphysema, sleep apnea or chronic lung disease?	❑	❑
b. The heart or circulatory system, including high blood pressure, high cholesterol, heart attack, heart murmur, heart valve disease or chest pain, irregular heart beat, TIA, varicose veins, phlebitis or blood clot?	❑	❑
c. The immune system, including but not limited to blood or spleen disorder, anemia, lupus, leukemia, purpura or lymphoma?	❑	❑
d. The digestive system, including ulcer, gastritis, esophagitis, esophageal reflux, intestinal disorder, colitis, hepatitis,cirrhosis, hemorrhoids, hernia or disorder of the pancreas, gallbladder, liver or rectum?	❑	❑
e. The nervous system, including epilepsy, convulsions,seizures, tremors, headaches, migraines, paralysis, stroke or TIA?	❑	❑
f. Mental disease or nervous disorder, including emotional problems, eating disorder, Attention Deficit Disorder, hyperactivity, anxiety, autism, depression, insomnia, developmental delay, psychiatric treatment, or counseling?	❑	❑
g. Diabetes, high or low blood sugar, glucose intolerance or any disorder of the thyroid gland, or any other glandular disorder including adrenal or pituitary?	❑	❑
h. The genito-urinary system, including any kidney disorder, kidney stones, cystitis, urinary tract infection or bladder infections or blood in the urine or sexually transmitted disease?	❑	❑
i. The muscular skeletal system treatment or disorder of the bone, joints, back or spine, including manipulation therapy, any muscular or neuromuscular disorder, including arthritis, gout, rheumatism, fibromyalgia or motor skill delay?	❑	❑
j. Any disorder of the facial bones, upper or lower jaw including temporomandibular joint disease (TMJ)?	❑	❑
k. Cancer, carcinoma in situ, or otherwise, tumor, cyst, acne or growth of any kind, skin disorder or ever had a tattoo?	❑	❑
l.Any disorder of the eyes (including cataracts, impaired sight or glaucoma),ears (including ear infections or tubes),nose, throat, tonsils, speech impediment or delay of hearing?	❑	❑
m. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), any condition related to AIDS or ARC or any disease or disorder of the immune system?	❑	❑
n. Any disorder or condition of male reproductive organs or prostate, elevated PSA test, infertility or impotence?	❑	❑

	Yes	No
21. Within the past 12 months, has any proposed insured experienced or been treated by a physician for:		
a. Weight gain or loss of more than 12 pounds?	❑	❑
b. Recurrent episodes of Diarrhea?	❑	❑
c. Swollen or enlarged glands or lymph nodes?	❑	❑
d. Persistent cough, persistent or recurrent fever, 10 or more viral infections?	❑	❑
e. Chronic or recurrent skin rashes or lesions?	❑	❑
22. Within the past 5 years, has any proposed insured:		
a. Been hospital confined, had surgery, advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery?	❑	❑
b. Had an EKG, MRI, chest x-ray, blood study, contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing health care services?	❑	❑
23. Has any proposed insured ever been:		
a. Treated or counseled for alcohol or drug use or attended a drug or alcohol support group?	❑	❑
b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption?	❑	❑
24. 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?	❑	❑
25. Does any proposed insured have a mental or physical impairment or deformity, or a congenital abnormality, disease or trait not previously disclosed?	❑	❑
26. 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?	❑	❑
27. FOR FEMALE APPLICANTS ONLY: Questions 27. a-d		
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 pillomavirus)?	❑	❑
b. Date of last Pap Smear_____ Results _____		
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?	❑	❑
d. Breast disorder, disease, changes, condition or lump(s), aspiration(s), calcifications, biopsies including removal or placement of breast implants or mammoplasty?	❑	❑

COMPLETE THE FOLLOWING FOR EACH "YES" ANSWER TO QUESTIONS 20 THROUGH 27 ABOVE.

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

SECTION I V — SUPPLEMENTAL INFORMATION
IMPORTANT INFORMATION CONCERNING THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU.

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?	❑ Yes	❑ No
2.	Are you a sole proprietor or a partner in a partnership?	❑ Yes	❑ No
3.	Are you an employee of a business?	❑ Yes	❑ No
	a. Will your employer pay a portion of your health insurance premium?	❑ Yes	❑ No
	b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium?	❑ Yes	❑ 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)?	❑ Yes	❑ 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.

APPLICATION DECLARATION & AGREEMENTS

I, the undersigned applicant 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 27; 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 certificate is issued (or this application is made to change an existing certificate, unless the change is approved) and the certificate 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 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 APPLICANT:
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 _____ (City) _____ (State) Date _____ Applicant’s Signature _____

Soliciting Agent (Please Print) _____ Spouse’s Signature _____

For Agent: Each question on the application was completed by the applicant(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 applicant 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 or until the person is no longer covered. 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.*

Date _____ Applicant's Signature _____

Witness _____ Spouse's Signature _____
(if coverage is requested for spouse)

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

Agent's Section

a) How long have you known the Applicant? _____

b) Who initiated the writing of this application? ❑ Agent/Broker ❑ Applicant

c) As a field underwriter, do you have any additional information that you believe will be helpful in underwriting this case? ❑ Yes ❑ No

d) As Agent/Broker, do you have any knowledge or reason to believe that replacement of existing insurance may be involved? ❑ Yes ❑ No

e) As Agent/Broker, have you complied with State Replacement Regulations? ❑ Yes ❑ No

Special Instructions To Home Office:

Are Commissions to be Split 50/50? ❑ Yes ❑ No If yes, list both agents'/brokers' names and PC #'s:

_____ _____

_____ _____

Dated At _____ This _____ day of _____ , 20___ _____
City State Soliciting Agent's/Broker's Signature

Licensed Agent's/Broker's PC # _____ SS # _____ Branch Code _____

Licensed Agent's/Broker's Fax # _____ Email Address _____

Field Office Check List:

* Has the application been reviewed for omissions and errors? ❑ Yes ❑ No
If "Yes", by (name) _____ Month _____ Day _____ Year _____

* Has the applicant signed the "Application Declaration & Agreements"? ❑ Yes ❑ No

* Have you printed, signed and dated the "Application Declaration & Agreements"? ❑ Yes ❑ No

* Have you left the "Notice of Privacy Practices" with the applicant? ❑ Yes ❑ No

* If Pre-Authorized Check mode of payment, have you attached a voided sample check? ❑ Yes ❑ No

* Have you attached an initial premium of at least one month? ❑ Yes ❑ No

* If Preferred Risk Discount applied for, have you included form ANL-2003a? ❑ Yes ❑ No

IMPORTANT NOTE TO AGENT
Do not collect any premium with this application, IF any proposed insured has:

1. Within the past two years been diagnosed as having, or been treated for, heart disease, cancer, mental or nervous disorder, liver or kidney disease; or
2. Any medical condition or injury for which medical treatment or advice will be sought.

Further, do not collect any premium with the application if,
for any other reason in your best judgement, the Company would not want to issue the policy.

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

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

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

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

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