

The American Champion Plus[®] Select



State Specific Forms

National Consumer's Advantage Association

Our NCAA members are armed with valuable consumer insight, health news and travel savings tips. Each member receives Car Rental Discount Coupons, Vision Care Discounts, Travel Club Benefits and various other consumer and discount materials.

To purchase the Health Insurance plan identified in the enclosed application, you must first be a member of National Consumer's Advantage Association. If you have questions regarding your membership, please call the Association at 1-800-992-8044.



NCAA

National Consumer's Advantage Association
1819 Clarkson Road, Ste. 301 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.



Attention Producer!

To apply for The American Champion Plus⁺[®] *Select* you must submit the following completed forms to the Home Office:

- ✕ **Form NCAAAP** — National Consumer's Advantage Association application (bottom)
- ✕ **Form ANL-3291** — Enrollment Application
- ✕ **Form ECM03** — Employee Census Form
- ✕ **Form 4635A** — HIPAA Review

Leave the items listed below with your client:

- ★ **American Champion Plus⁺[®] *Select* Brochure**
- ★ **Form NCAAAP** — National Consumer's Advantage Association description (top)
- ★ **Form COLINFO** — Notice to Applicant & Collection of Information
- ★ **Form ANL-4635** — HIPAA Information

Please check for List Bill availability in your state!

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.

**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)
1. I, as an NCAA Member, apply for:

Home Office Use

- Plan: ANL-2001 (Indemnity)
 Plan: ANL-2001 (PPO)

- Basic Deductible Amount:**
 \$500 \$2,000
 \$750 \$2,500
 \$1,000 \$5,000
 \$1,500 \$10,000

Optional Riders:

- Accident Expense Benefit Yes No
 \$300 \$500
Hospital Admission Deductible Yes No
 \$500 \$750 \$1,000
 \$1,500 \$2,000 \$2,500
Maternity Yes No
Deductible: \$1,000 \$2,000
24-Hour Coverage Yes No
Doctor's Office Copay Yes No
Brand Name Prescription Drug Yes No
Other: _____

2. Special Requests

Co-Insurance:

- 80/20 — **Stoploss:** \$5,000 \$10,000
 50/50 — **Stoploss:** \$3,000 \$5,000 \$10,000

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		Sex	Age	Date of Birth				Build		Social Security #
		Single	Married			Mo.	Day	Year	State	Height	Weight	
1	Applicant	<input type="checkbox"/>	<input type="checkbox"/>									
2	Spouse	<input type="checkbox"/>	<input type="checkbox"/>									
3												
4												
5												
6												

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

Number and Street or R.F.D. _____

City _____ State _____ Zip _____

Phone: Hm() _____

Wk() _____

E-mail Address: _____

Best time to call:

A.M. P.M.

A.M. P.M.

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 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 (If the answer to any of the following is "Yes", this section must be fully completed).

- 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? (If "Yes", give details)

List below all medical insurance now in force or applied for.

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 (If "Yes", give details)

15. Has any proposed insured applied for life, accident or health insurance or for reinstatement of such insurance, which was declined, restricted, postponed, 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, bungee jumping, 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's within the past 2 years? Yes No (If "Yes", give details.)

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

**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>20. Within the last 10 years has any proposed insured had any indication of, diagnosis of, or treatment for:</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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, elevated cholesterol, varicose veins, phlebitis or blood clot? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. The immune system, including but not limited to blood or spleen disorder, anemia, lupus, leukemia, purpura or lymphoma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. The digestive system, including ulcer, gastritis, esophagitis, esophageal reflux, intestinal disorder, colitis, gallbladder, hemorrhoids, hernia or disorder of the pancreas, liver or rectum? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. The nervous system, including epilepsy, convulsions, seizures, tremors, headaches, migraines, paralysis, stroke or TIA? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Mental disease or nervous disorder, including emotional problems, Attention Deficit Disorder, hyperactivity, anxiety, autism, depression, developmental delay, psychiatric treatment, or counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Any disorder of the facial bones, upper or lower jaw including temporomandibular joint disease (TMJ)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Cancer, in situ or otherwise, tumor, cyst, acne or growth of any kind, skin disorder or ever had a tattoo? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Any disorder of the eyes (including cataracts or glaucoma), ears (including ear infections or tubes), nose, throat, tonsils, impaired sight, speech impediment or delay or hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>n. Any disorder or condition of male reproductive organs or prostate, elevated PSA test, infertility or impotence? <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:</p> <p>a. Weight gain or loss of more than 12 pounds? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Recurrent episodes of Diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Swollen or enlarged glands or lymph nodes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Persistent cough, persistent or recurrent fever, 10 or more viral infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Chronic or recurrent skin rashes or lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. 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"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Has any proposed insured ever been:</p> <p>a. Treated or counseled for alcohol use or attended Alcoholics Anonymous? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Treated or counseled for drug addiction, dependency or abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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 stints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Does any proposed insured have a mental or physical impairment or deformity, or a congenital abnormality, disease or trait not previously disclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Is any proposed insured taking medication or receiving treatment of any kind for any condition not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. FOR FEMALE APPLICANTS ONLY: Questions 27. a-d</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"/> Yes <input type="checkbox"/> No</p> <p>b. Date of last Pap Smear _____
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"/> Yes <input type="checkbox"/> No</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"/> Yes <input type="checkbox"/> No</p> |
|--|---|

COMPLETE THE FOLLOWING FOR EACH “YES” ANSWER TO QUESTIONS 20 THROUGH 27 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, Due Date	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.

SECTION IV — 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? | <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.

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 coded 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 _____ Date _____ Applicant's Signature _____
City State

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 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 except to the extent that action 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:
power of attorney, guardian-in-fact, guardian, payee representative, other (Circle One) _____

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 an Outline of Coverage 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

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**



*American National Life Insurance Company of Texas
Galveston, Texas*