

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. Within the past 12 months, have you applied for coverage which was restricted or rated up ?				

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

Applicant Date

Spouse Date

Drivers license number State

Drivers license number State

Licensed Agent Date

Agent number

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



**ANTEX Faxed Application Process
Application Cover Sheet**

FACSIMILE TRANSMITTAL SHEET - ONE APPLICATION PER COVER SHEET

TO:
MIG HEALTH UNDERWRITING DEPT.

ANTEX FAX NUMBER:
1-800-660-7948

DATE:

TOTAL NO. OF PAGES INCLUDING COVER:

Agent Information (MUST BE COMPLETED)

NAME:

SSN and/or PC#

TELEPHONE #:

FAX #:

ADDRESS:

E-MAIL ADDRESS:

Applicant's Information (MUST BE COMPLETED)

NAME:

DOB:

The attached application is being submitted to ANTEX for processing. Upon receiving the application a policy number will be assigned.

A return confirmation fax will be sent within 24 hours to the fax number/e-mail address indicated above. The return fax will include the assigned policy number and instructions for mailing the initial premium check. It is important that the policy number is noted on the check.

**PLEASE INCLUDE A COPY OF THE QUOTE AND A COPY OF THE VOIDED CHECK (IF MONTHLY ELECTRONIC DEBIT IS SELECTED) WITH YOUR FAX.
DO NOT MAIL THE CWA CHECK UNTIL THE RETURN FAX IS RECEIVED.**

Any necessary forms not received with the application will be indicated on the return fax in order to issue the policy promptly.



SECTION I - RAPID ASSESSMENT

The purpose of this section is to determine the eligibility of all applicants, including spouse and any dependents.
 Use the previous page to answer the following questions:

1. Does any proposed insured have or ever had any of the ineligible medical conditions listed on the preceeding page? Yes No
2. Does the height and weight of any proposed insured fall outside the height and weight chart listed on the preceeding page?
 Yes No
3. Is any proposed insured employed in or participate in any of the ineligible occupations listed on the preceeding page? Yes No
4. Is any proposed insured or household member (including students away at school, whether or not applying for coverage at this time) currently pregnant? (If "Yes," coverage cannot be provided.) Yes No
5. Does any proposed insured have any surgeries or special tests that have been recommended or scheduled, but have not yet been performed? Yes No
6. Is the proposed insured applying for coverage under the federal HIPAA program? (If "Yes," please submit an application through regular business channels.) Yes No
7. Has any proposed insured been arrested and/or convicted of DUI/DWI in the past 2 years? Yes No

SECTION II - PLAN INFORMATION

I, as an association member, apply for (choose one):

- Major Med Light (ANL-2003-PN) ***Please Check For State Availability*****
Options and Plan Design
 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 Million \$7 Million
 Outpatient Prescription Drug Rider: \$500 Deductible \$1,000 Deductible None

- The American Champion Plus[®] Select (ANL-2001-P) *** Available In The Following States: AR, AZ, DE, IA, IL, IN, LA, MI, MO, NE, OH, OK, NV, PA, SC, TN, TX, UT, VA, WI, and WY *****

- The American Champion Plus[®] (ANL-2000A-PMS) *** Available In The Following States: GA, KS, NC and WV *****
Options and Plan Design
 Plan: PPO Indemnity
 Deductible Amount: \$500 \$750 \$1,000 \$1,500 \$2,000 \$2,500 \$5,000 \$10,000
 Co-Insurance: 80/20 ----- Stoploss: \$5,000 \$10,000
50/50 ----- Stoploss: \$3,000 \$5,000 \$10,000
 Doctor's Office Co-Pay (with PPO only): Yes No
 Prescription Drug Rider (with PPO only): Yes No
 Hospital Admission Deductible: \$500 \$750 \$1,000 \$1,500 \$2,000 \$2,500 None
 Accident Expense Benefit: \$300 \$500 None
 24-Hour Coverage: Yes No

SECTION III - AGENT INFORMATION

Dated At _____ this day of _____, 20_____
Soliciting Agent's/Broker's Signature
 Licensed Agent's/Broker's Writing # _____ Social Security # _____ Branch Office Code _____
 Licensed Agent's/Broker's Fax # _____ Email Address _____

SECTION IV - NCAA MEMBERSHIP APPLICATION

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.

Please Choose One: Silver Membership (\$2.50 per month or \$30 annually) Gold Membership (\$4.50 per month or \$54 annually)
 Member Name (please print) _____ Member Signature _____

SECTION V - APPLICANT INFORMATION

1. Proposed Insured Information

Proposed Insured(s) <i>(Print Last Name, First Name, MI)</i>	Relationship	Marital Status		Gender	Age	Date of Birth <i>(MM/DD/YYYY)</i>	Social Security Number
		Single	Married				
1.	<i>Applicant</i>	<input type="checkbox"/>	<input type="checkbox"/>				
2.	<i>Spouse</i>	<input type="checkbox"/>	<input type="checkbox"/>				
3.							
4.							
5.							
6.							

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

Number and Street or R.F.D. _____
 City State Zip Code _____

3. Contact Information

Best Time To Call:
 Phone: Hm(____) A.M. P.M.
 Wk(____) A.M. P.M.
 Email Address: _____

SECTION VI - BILLING INFORMATION

Quarterly **Semi-Annual** **Annual** **Monthly Electronic Debit** - *Funds will be withdrawn from the account number shown on the CWA check, otherwise, submit a copy of a voided check or deposit slip to establish a different account for premium withdrawal.*

Name Address City State Zip Code

Effective Date: _____ Draft Date *(if other than effective date)*: _____
 (The effective date is the latter of the Home Office approval date or requested effective date. 29th, 30th and 31st dates are not available.)

SECTION VII - SUPPLEMENTAL INFORMATION

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.

- 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
 - 3a. Will your employer pay a portion of your health insurance premium? Yes No
 - 3b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium? Yes No
 - 3c. 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

SECTION VIII - DECLARATION FOR FAX-AN-APP ENROLLMENT APPLICATION

Once an application has been completed and submitted to the Home Office, a review of all applicants' complete medical histories will be performed during the Personal History Interview. All applicants are subject to underwriting rules and regulations. **Please be advised the Home Office will contact the applicants to complete the Personal History Interview with the telephone number(s) provided on the application.** The applicants will need to provide detailed information regarding the medical history, including the diagnosis of medical conditions, dates of treatment, and any testing performed (including the date of full recovery, names and dosage of medication, and names and addresses or telephone numbers of medical practitioners).

IT IS DECLARED that statements and answers in the Fax-An-App Enrollment application are complete and true to the best knowledge and belief of the undersigned. All questions on the Fax-An-App Enrollment Application are true, complete and correctly recorded and it is agreed they will be used to determine the eligibility for coverage under the health insurance plan for which each applicant is applying. I understand and agree that: 1)"Proposed Insured" means all persons named in question 1; 2) all statements and answers in the Fax-An-App Enrollment Application are complete and true; 3) I/we have personal knowledge of the medical history of each Proposed Insured; 4) any incorrect or incomplete information on the Fax-An-App Enrollment Application may result in loss of coverage or claim; 5) no insurance shall take effect unless the certificate is issued and actually delivered to the Proposed Insured(s) and the first full premium paid during the life time and good health of all Proposed Insured(s). I will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the plan. I also understand and agree 1) eligibility for the coverage does and constitutes initial coverage and 2) initial coverage under the Group Policy is subject to the Company's underwriting criteria. I further acknowledge that I have received and read the material contained in this packet describing the rights of Eligible Individuals under HIPAA and understand its contents.

Applicant's Signature _____ Date _____
 Spouse's Signature _____ Date _____

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.

SECTION IX - AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National Life Insurance Company of Texas underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL LIFE NSURANCE COMPANY of TEXAS for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization except to the extent that action has 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 _____

Fax-An-App Interview Worksheet

To Be Left With
The Client!

Thank you for your interest in our group association insurance. Please use this form to assist you in outlining the medical history of each family member applying for insurance. Have it ready when one of our interview representatives contacts you to complete the personal history telephone interview. Please allow 15 minutes for the interview. Interview time may vary. If you have not been contacted within 48 hours, please call us toll free at 1-866-214-6973 between 8:00 a.m. and 4:30 p.m. CST, Monday through Friday.

Preparing For The Interview:

- ◆ Have your prior or current insurance information on hand; this should include the effective date, termination date and type of insurance. **Do not cancel existing coverage until you have received your new certificate from the Company.**
- ◆ Review the *Medical Conditions List* located on the back of this form.
- ◆ For each condition that applies, please indicate which family member(s) it pertains to and provide details in the chart provided below.
- ◆ During the Fax-An-App interview, be prepared to provide details of medical conditions, including dates, doctors, treatment, etc. for the for each person who is applying.

	Current Height & Weight	Date of Last Physical	Medical Conditions In the Past 10 Years	Dates of Last Treatment	Physician Names, Addresses & Phone Numbers	Treatment & Names of Medications
Example	Suzy Doe 5'6" 140lbs	August 2003	Allergies Arthritis Headaches	Allergies- 2 weeks Arthritis- pm Headaches- within 2 weeks	Dr. John Sneeze- Allergist Dr. Bones- Ortho Dr. Skully- Neurology	Allegra Flonase Imitrex Viross
Primary Applicant						
Spouse						
Dependent 1						
Dependent 2						
Dependent 3						
Dependent 4						

Thank you again for choosing ANTEX for your health insurance. Please keep this form for your records.

Interview Preparation Form

MEDICAL CONDITIONS LIST

Including but not limited to:

Lungs/Respiratory System

Hay fever, allergies, sinus infections, reactive airway disease, asthma, bronchitis, pneumonia, emphysema, sleep apnea, chronic obstructive pulmonary disease

Heart/Circulatory System

High blood pressure, high cholesterol, heart attack, heart murmur, heart valve disease, chest pain, irregular heart beat, varicose veins, blood clot, phlebitis, congenital heart defects, stroke

Immune/Hemopoietic System

Blood or spleen disorder, anemia, purpura, Acquired Immune Deficiency Syndrome, lupus, leukemia, lymphoma, ARC or any disease of the immune system

Digestive System

Ulcer, gastritis, esophagitis, esophageal reflux, colitis, hemorrhoids, hernia, pancreatitis, hepatitis, cirrhosis, any disease of the pancreas, gallbladder, liver, intestine or rectum

Nervous System

Epilepsy, tremors, headaches, migraines, paralysis, stroke, transient ischemic attack, neuralgia, autism, any disease of the nervous system

Mental/Nervous Disorders

Mental or nervous disorder, emotional problems, autism, attention deficit disorder, hyperactivity, anxiety, depression, developmental delay, psychiatric treatment or counseling, anorexia, bulimia, insomnia

Endocrine Disorders

Diabetes mellitus, diabetes insipidus, high or low blood sugar, glucose intolerance, hyperthyroidism, hypothyroidism, goiter, adrenal gland disorder, pituitary gland disorder, or any other glandular disorder

Urinary System

Kidney stones, urinary tract infections, bladder infections, blood in the urine, fallen bladder, cysts, or any disease of the kidneys or urinary tract

Male Reproductive System

Prostatitis, enlarged prostate, elevated PSA, sexually transmitted diseases, or any disorder of the male reproductive organs

Musculoskeletal System

Any treatment or disorder of the bones, joints, back or spine, manipulation therapy, any muscular or neuromuscular disorder, including arthritis, gout, rheumatism, fibromyalgia or motor skill delay, osteopenia/osteoporosis, chronic fatigue syndrome

Skin Disorders

Acne, skin cancer, rosacea, eczema, psoriasis, tattoo, actino keratosis, moles, dermatitis, lentigo, warts, cellulitis, hemangioma, keloid

Ears/Eyes/Nose/Mouth Disorders

Any disorder of the eyes including cataracts, glaucoma, impaired vision, otitis/ear infections, ear tubes or hearing impairment or any disorder of the ears, tonsil/adenoid hypertrophy, tonsillitis, deviated septum, leukoplakia, cleft lip, cleft palate, malocclusion, TMJ

Infectious Disease

Lyme Disease, poliomyelitis, histoplasmosis, sarcoidosis, malaria, tuberculosis, fungus diseases

Breast Disorder

Breast implants, fibrocystic breast disease, lumps, aspirations, calcifications, biopsies, breast reduction, breast tumor, breast cyst

Cancer/Tumor/Cyst/Etc.

Cancer of all types, cancer in situ, growth, cyst, polyp, neoplasm

Female Reproductive Organs

Disorder or condition of the female reproductive organs, abnormal PAP smear, irregular or excessive menstruation, endometriosis, infertility, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, or HPV (human papilloma virus) or other sexually transmitted diseases, PMS

PAP Smear Abnormalities

Cervicitis, dysplasia, inflammation, cervical cancer, atypical cells, HPV (human papilloma virus)

Pregnancy Complications

Ectopic pregnancy, gestational diabetes, miscarriage, pre-eclampsia, high blood pressure, cesarean section, incompetent cervix

Miscellaneous

Weight gain or loss, recurrent episodes of diarrhea, persistent cough, persistent or recurrent fever, chronic or recurrent skin rashes or lesions, congenital abnormality/disorder, alcohol abuse, drug use/abuse

Diagnostic Testing

EKG, stress test, CT scan, colonoscopy, EEG, blood test, chest x-ray, angiogram, ultrasound, EGD, bone density, echocardiogram, MRI, mammogram, Holter monitor, urinalysis

Fixation/Prosthetic Devices

Plates, implants, pacemaker, screws, valve replacement, shunts, stents, joint replacements, rods, pins

For those medical conditions that you or any person applying for coverage were diagnosed with, received treatment for, or consulted a physician for within the past 10 years and are not listed above, please note the condition below.

HAZARDOUS ACTIVITIES AND DRIVING

Hazardous Activity

Participation in any hazardous activity, automobile racing, skydiving, hang gliding, motorcycle racing, ultralight flying, powerboat racing, scuba diving, dirt bike riding, bungee jumping, professional sports, piloting an aircraft, rodeo activities, martial arts

Driving Record

Any adverse driving history, reckless driving, moving violations (past 2 years), speeding, any arrests, driver's license suspension