Application for Individual Life Insurance

American National Life Insurance Company of New York

Mailing Address Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Phone 1-866-490-3163

Part 1: Note: Complete and thorough answers to all of the following questions will help to ensure efficient and accurate processing of your application. For any question that requires additional detail, you may attach a sheet of paper, if necessary.

1. Primary Proposed Insured

a. Name: Last | First | M.I. | b. Birthplace: City | State | Country

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number:

f. Gender: ☐ Male ☐ Female g. Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

h. Residence Address: Number/Street | City | State | ZIP

i. Years at this Residence: | j. Phone Number: Home | Cell Phone: | If a phone interview is needed, which is preferred number? ☐ Home ☐ Cell

k. Annual Income: $ | Net Worth: $ | E-mail Address:

l. Occupation/Job Title: | m. Employer Name: | n. Type of Business:

o. Job Duties (Be Specific): | p. Duration of Employment:

q. Business Address: Number/Street | City | State | ZIP

r. Are you a U.S. Citizen? ☐ Yes ☐ No

If No, are you a legal permanent resident of the U.S.? ☐ Yes ☐ No

If No, do you have a VISA? ☐ Yes ☐ No

If Yes, type of VISA: _____. *Expiration date:* _____.

If No, please complete Residency Questionnaire.

2. Juvenile Primary Proposed Insured *(To be completed when Primary Proposed Insured is 14 years and 6 month or younger. Do not complete if applying for Children's Term Rider.)*

a. Is the owner a parent of the proposed juvenile insured? ☐ Yes ☐ No

If No, is the owner a grandparent of the proposed juvenile insured? ☐ Yes ☐ No

If No, is the owner a legally appointed guardian who is responsible for the financial support of the proposed juvenile insured? ☐ Yes ☐ No

b. What is the combined annual income and net worth of the proposed juvenile insured's parents (or legally appointed guardian)?
Annual Income: $ | Net Worth: $

c. How much Life Insurance is currently in force on the proposed juvenile insured? $ _____

d. How much Life Insurance does each parent (or legally appointed guardian) have on his/her own life?
Mother: $ | Father: $ | Guardian: $

e. Are there any other minor siblings in the home? ☐ Yes ☐ No

If Yes, do the siblings have the same amount of coverage in force/applied for? ☐ Yes ☐ No

If No, explain: _____

f. If the proposed juvenile insured is under the age of 1, was the birth considered premature? ☐ Yes ☐ No

g. If the proposed juvenile insured is under the age of 1, what was his or her birth weight? _____lbs. _____ oz.

3. Additional Proposed Insured

a. Name: Last | First | M.I. | b. Birthplace: City | State | Country

c. Date of Birth: Month/Day/Year | d. Age: | e. Social Security/Tax ID Number:

f. Gender: ☐ Male ☐ Female g. Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

h. Residence Address: Number/Street | City | State | ZIP

i. Years at this Residence: | j. Phone Number: Home | Cell Phone: | If a phone interview is needed, which is preferred number? ☐ Home ☐ Cell

k. Annual Income: $ | Net Worth: $ | Relationship to primary proposed insured

l. Occupation/Job Title: | m. Employer Name: | n. Type of Business:

o. Job Duties *(Be Specific)*: | p. Duration of Employment:

q. Business Address: Number/Street | City | State | ZIP

r. Are you a U.S. Citizen? ☐ Yes ☐ No

If No, are you a legal permanent resident of the U.S.? ☐ Yes ☐ No

If No, do you have a VISA? ☐ Yes ☐ No

If Yes, type of VISA: _____. *Expiration date:* _____.

If No, please complete Residency Questionnaire.

4. Primary Ownership *(if other than Primary Proposed Insured)*

If owner is an individual:

a. Name: Last | First | M.I. | b. Relationship of the Primary Owner to Primary Proposed Insured:

c. Gender: ☐ Male ☐ Female

d. Date of Birth: Month/Day/Year | e. Social Security/Tax ID Number:

f. Residence Address: Number/Street | City | State | ZIP

Phone Number: | E-mail Address:

If owner is a business:

a. Name of Business: | b. Date Established: | c. Tax ID Number:

d. Business Address: Number/Street | City | State | ZIP

If owner is a trust:

a. Name of Trust: | b. Date Trust was created:

c. Type of Trust: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Other *(Explain)* _____

5. Contingent Ownership *(Optional ownership, if any)*

a. Name: Last | First | M.I. | b. Relationship of the Contingent Owner to Primary Proposed Insured:

c. Date of Birth: Month/Day/Year | d. Social Security/Tax ID Number:

6. Designated Third Party Addressee *(You can specify another person to receive notices of past due premiums and pending lapses.)*

a. Name: Last ______ | First ______ | M.I. ______

b. Residence Address: Number/Street ______ | City ______ | State ______ | ZIP ______

7. Primary Beneficiary *(Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life Insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)*

If beneficiary is an individual:

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Beneficiary to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: ______ | f. Percentage Payable: ______%

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Beneficiary to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: ______ | f. Percentage Payable: ______%

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Beneficiary to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: ______ | f. Percentage Payable: ______%

If beneficiary is a business:

a. Name of Business: ______ | b. Date Established: ______ | c. Tax ID Number: ______

If beneficiary is a trust:

a. Name of Trust: ______ | b. Date Trust was created: ______

c. Type of Trust: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Other *(Explain)* ______

8. Contingent Beneficiary *(Date of Birth is required for each beneficiary. Complete Application - Additional Beneficiary Page for Life insurance if additional space is needed. Unless otherwise directed, all beneficiaries in the same class will share equally.)*

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Contingent Beneficiary to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: ______ | f. Percentage Payable: ______%

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Contingent Beneficiary to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ d. Gender: ☐ Male ☐ Female | e. Social Security/Tax ID Number: ______ | f. Percentage Payable: ______%

9. Children Proposed for Term Rider Coverage

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Proposed Child to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ | d. Age: ______ | e. Social Security/Tax ID Number: ______ f. Gender: ☐ Male ☐ Female

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Proposed Child to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ | d. Age: ______ | e. Social Security/Tax ID Number: ______ f. Gender: ☐ Male ☐ Female

(Continuation of Section 9)

a. Name: Last ______ | First ______ | M.I. ______ | b. Relationship of the Proposed Child to Primary Proposed Insured: ______

c. Date of Birth: Month/Day/Year ______ | d. Age: ______ | e. Social Security/Tax ID Number: ______ f. Gender: ☐ Male ☐ Female

g. Has the name of any child age 18 or younger been omitted? ☐ Yes ☐ No
If Yes, explain. ______

h. If child is under the age of 1, was the birth considered premature? ☐ Yes ☐ No
If Yes, how many weeks premature? ______ weeks
Duration of hospitalization? ______ weeks

i. If child is under the age of 1, what was his/her birth weight? ______ lbs. ______ oz.

j. Has any child proposed for term rider coverage **EVER** been diagnosed or treated by a member of the medical profession for any disease or disorder of: the heart; cancer; tumor; seizure disorder/epilepsy; diabetes; respiratory disease; birth defect; psychiatric or behavior abnormality including attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)? *(If Yes, provide details below, including child's name and disease or disorder.)* ☐ Yes ☐ No

______

______

______

10. Purpose of Coverage *(If amount of insurance is greater than $250,000)*

a. If personal coverage: ☐ Income Replacement ☐ Debt Repayment ☐ Estate Planning/Conservation ☐ Other ______

b. If business coverage: ☐ Key Person ☐ Buy/Sell ☐ Deferred Compensation ☐ Loan Protection ☐ Other ______

11. Other Insurance and Replacements

a. I have read the Important Replacement Notice form that accompanied this application. ☐ Yes ☐ No

b. Do you have existing life insurance or annuity coverage with this, or any other company? (*If Yes, complete Other Insurance and Replacement Details.)* ☐ Yes ☐ No

c. If Yes, is the insurance applied for intended to replace, change, or use cash values of any existing life insurance or annuity issued by any company? (*If Yes, complete Other Insurance and Replacement Details.)* ☐ Yes ☐ No

d. In the **past 6 months**, has any proposed insured applied for - or is any proposed insured currently contemplating applying for - other life insurance with this, or any other company? *(If Yes, state how much and to whom.)* ☐ Yes ☐ No

______

e. Other Insurance and Replacement Details:

Full Company Name: ______ | Policy/Contract Number: ______ ☐ Life ☐ Annuity Status: ☐ In Force Issue Date: ______ ☐ Pending Application Date: ______

Insured/Annuitant's Name: ______ | Plan: ______ | Amount: $ ______ Replacement? ☐ Yes ☐ No 1035 Exchange? ☐ Yes ☐ No

Full Company Name: ______ | Policy/Contract Number: ______ ☐ Life ☐ Annuity Status: ☐ In Force Issue Date: ______ ☐ Pending Application Date: ______

Insured/Annuitant's Name: ______ | Plan: ______ | Amount: $ ______ Replacement? ☐ Yes ☐ No 1035 Exchange? ☐ Yes ☐ No

Full Company Name: ______ | Policy/Contract Number: ______ ☐ Life ☐ Annuity Status: ☐ In Force Issue Date: ______ ☐ Pending Application Date: ______

Insured/Annuitant's Name: ______ | Plan: ______ | Amount: $ ______ Replacement? ☐ Yes ☐ No 1035 Exchange? ☐ Yes ☐ No

12. Insurance History and Non-Medical Hazards

a. In the **past 5 years**, has any proposed insured applied for life, accident, or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn, or modified as to plan, amount, or rate? *(If Yes, provide details below.)* ☐ Yes ☐ No

b. In the **past 5 years**, has any proposed insured engaged in – or within the **next 2 years** does any proposed insured intend to engage in flights as a pilot, student pilot, crew member, or observer? (Does not apply to travel as a passenger on a commercial flight.) *(If Yes, complete Aviation Questionnaire.)* ☐ Yes ☐ No

c. In the **past 5 years**, has any proposed insured engaged in - or within the **next 2 years** does any proposed insured intend to engage in mountain climbing, rock climbing, racing, SCUBA diving, hang gliding, ballooning, or sky diving? *(If Yes, complete appropriate questionnaire.)* ☐ Yes ☐ No

d. In the **past 10 years**, has any proposed insured plead guilty or been convicted of a felony or have any felony charges currently pending (You may respond to questions about convictions specified in N.Y. Executive Law § 296(16) as if the convictions did not occur.)? *(If Yes, provide details below.)* ☐ Yes ☐ No

e. In the **past 12 months**, has any proposed insured been or are you currently on probation or parole (You may respond to questions about convictions specified in N.Y. Executive Law § 296(16) as if the convictions did not occur.)? *(If Yes, provide start and end date.)* ☐ Yes ☐ No

f. Do you intend to travel or reside outside the U.S. or Canada in the **next 2 years**? ☐ Yes ☐ No

If Yes, where? _____

13. Driving History

Primary Proposed Insured:

a. Do you have a driver's license? ☐ Yes ☐ No

If Yes, what is the driver's license number and issue state? DL#: _____ State: _____

*If No, have you **EVER** had a driver's license?* ☐ Yes ☐ No

b. In the **past 5 years**, have you been convicted of any of the following (You may respond to questions about convictions specified in N.Y. Executive Law § 296(16) as if the convictions did not occur.)?

- driving under the influence or driving while impaired ☐ Yes ☐ No

  If Yes, provide date and details regarding sentence: Date: _____ Details: _____

- Reckless Driving ☐ Yes ☐ No

  If Yes, provide date and details regarding sentence: Date: _____ Details: _____

Additional Proposed Insured:

a. Do you have a driver's license? ☐ Yes ☐ No

If Yes, what is the driver's license number and issue state? DL#: _____ State: _____

*If No, have you **EVER** had a driver's license?* ☐ Yes ☐ No

b. In the **past 5 years**, have you been convicted of any of the following (You may respond to questions about convictions specified in N.Y. Executive Law § 296(16) as if the convictions did not occur.)?

- driving under the influence or driving while impaired ☐ Yes ☐ No

  If Yes, provide date and details regarding sentence: Date: _____ Details: _____

- Reckless Driving ☐ Yes ☐ No

  If Yes, provide date and details regarding sentence: Date: _____ Details: _____

Part 2:

14. Physician/Facility that has Most Complete Medical Records on Proposed Insured

Primary Proposed Insured:

a. Physician/Facility Name:

b. Address: Number/Street | City | State | ZIP | c. Phone:

d. Date Last Seen: | e. Reason:

Additional Proposed Insured:

a. Physician/Facility Name:

b. Address: Number/Street | City | State | ZIP | c. Phone:

d. Date Last Seen: | e. Reason:

15. Build

Primary Proposed Insured:

a. What is the proposed insured's height and weight? ..... Feet Inches Pounds

b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery? *(If Yes, provide details below.)* ..... ☐ Yes ☐ No

Additional Proposed Insured:

a. What is the proposed insured's height and weight? ..... Feet Inches Pounds

b. In the **past year**, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery? *(If Yes, provide details below.)* ..... ☐ Yes ☐ No

16. Tobacco Use Information

Primary Proposed Insured:

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? ..... ☐ Yes ☐ No
If Yes, provide details for all types of nicotine/tobacco used.

Type:	Type:	Type:
Frequency:	Frequency:	Frequency:
☐ Daily	☐ Daily	☐ Daily
☐ Occasionally/Socially	☐ Occasionally/Socially	☐ Occasionally/Socially
☐ No Longer Use	☐ No Longer Use	☐ No Longer Use
Date of Last Use:	Date of Last Use:	Date of Last Use:

Additional Proposed Insured:

a. Have you **EVER** used tobacco or nicotine in any form including, but not limited to: chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches? ..... ☐ Yes ☐ No
If Yes, provide details for all types of nicotine/tobacco used.

Type:	Type:	Type:
Frequency:	Frequency:	Frequency:
☐ Daily	☐ Daily	☐ Daily
☐ Occasionally/Socially	☐ Occasionally/Socially	☐ Occasionally/Socially
☐ No Longer Use	☐ No Longer Use	☐ No Longer Use
Date of Last Use:	Date of Last Use:	Date of Last Use:

17. Human Immunodeficiency Virus (AIDS)

(For questions 17 through 21c, provide details in Section 22.)

Has any proposed insured **EVER** been diagnosed or treated by a licensed member of the medical profession for AIDS and/or the HIV infection? ..... ☐ Yes ☐ No

18. Medical History - Lifetime

Has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding…

a. Heart disease, including: heart attack; coronary artery blockage; angina; heart failure; cardiomyopathy; irregular heartbeat; or disease or disorder of the heart? ☐ Yes ☐ No
b. Stroke, Transient Ischemic Attack (TIA/mini-stroke), carotid artery disease, peripheral vascular disease, poor circulation, aneurysm, or any other disease or disorder of the blood vessels? ☐ Yes ☐ No
c. Cancer, tumor, abnormal growth, lump, mass, melanoma, lymphoma, or leukemia? ☐ Yes ☐ No
d. Anemia, clotting disorder, or any disease or disorder of the blood (excluding a positive HIV test)? ☐ Yes ☐ No
e. Any diseases or disorders of the immune system except for those related to the HIV infection? ☐ Yes ☐ No

19. Medical History - Last 10 Years

In the past 10 YEARS, has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding…

a. High blood pressure? ☐ Yes ☐ No
b. Diabetes or abnormal blood sugar to include high blood sugar or low blood sugar? ☐ Yes ☐ No
c. Depression, anxiety, attention deficit/hyperactivity disorder, bipolar disorder, schizophrenia, post-traumatic stress disorder, or psychiatric treatment? ☐ Yes ☐ No
d. Asthma, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, sleep apnea, tuberculosis, or any disease or disorder of the lungs? ☐ Yes ☐ No
e. Gastrointestinal bleeding, ulcers, Crohn's disease, Barrett's esophagus, ulcerative colitis, hepatitis, cirrhosis, colon polyps, or any other disease or disorder of the esophagus, stomach, intestines/colon, rectum, liver or pancreas? ☐ Yes ☐ No
f. Any disease or disorder of the kidneys, urinary bladder, blood in urine, protein in urine, prostate disorder including abnormal PSA (prostate specific antigen), ovaries, uterus, or cervix including abnormal Pap smear?. ☐ Yes ☐ No
g. Disorder of the thyroid, pituitary gland, parathyroid glands, or adrenal glands? ☐ Yes ☐ No
h. Arthritis, fibromyalgia, chronic pain, chronic back pain, or any joint or muscle condition? ☐ Yes ☐ No
i. Lupus, scleroderma, any connective tissue disease, or any autoimmune disorder? ☐ Yes ☐ No
j. Seizures/epilepsy, tremors, multiple sclerosis, paralysis, Alzheimer's, dementia, Parkinson's, blindness or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

20. Drugs/Alcohol History

In the past 10 YEARS, has any proposed insured…

a. Used marijuana in any form? ☐ Yes ☐ No
b. Used cocaine, barbiturates, crack, ecstasy, methamphetamine, heroin, LSD or hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No
c. Been addicted to prescription medication or been advised by a licensed medical professional to discontinue habit forming drugs? ☐ Yes ☐ No
d. Been advised by a licensed medical professional to cease or reduce alcohol use or been advised to get medical treatment, or undergone any medical treatment, counseling, or hospitalization for alcoholism, excessive alcohol use or abuse? ☐ Yes ☐ No

21. Medical History - Last 5 Years

In the past 5 YEARS, has any proposed insured…

a. Had any consultation, testing, surgery or investigation scheduled or recommended by a member of the medical profession that has not yet been completed (excluding routine checkups, preventative care, pregnancy and HIV)? ☐ Yes ☐ No
b. Applied for or received any disability benefits (other than maternity) from any insurance company, government, employer, or other source? ☐ Yes ☐ No
c. Taken any prescription medications other than what has already been disclosed on the application? ☐ Yes ☐ No
(If Yes, list medications below)

_____

22. Medical History Explanations

(Give full details below of all Yes answers to questions in Sections 17 through 21.)

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

Question: Person: Reason, Condition, Disease, Injury, Medication(s), Etc.: Date of Diagnosis:

Name of Attending Physician: Attending Physician Address: Number/Street City State Phone #:

23. Family History *(If amount of insurance is greater than $100,000)*

Primary Proposed Insured:

Father:

a. Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma? . ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is father deceased? ..... ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Mother:

a. Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma?... ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is mother deceased? ..... ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Siblings:

a. How many siblings do you have? ..... _____

b. Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma? ..... ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

c. Are any siblings deceased?..... ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Additional Proposed Insured:

Father:

a. Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma? . ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is father deceased? ..... ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Mother:

a. Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer or melanoma?... ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

b. Is mother deceased? ..... ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Siblings:

a. How many siblings do you have? ..... _____

b. Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, ovarian cancer, prostate cancer or melanoma? ..... ☐ Yes ☐ No

- *If Yes, please indicate condition and age at diagnosis:* _____

c. Are any siblings deceased?..... ☐ Yes ☐ No

- *If Yes, please indicate cause and age at death:* _____

Insert Supplemental Application for Individual Life Insurance

Application Signatures

By signing this application I agree to the following statements and assurances:

- I have read the application and represent that all statements and answers as they pertain to me and such statement and answers are true and complete to the best of my knowledge and belief.
- My signature will be applied to this Life Insurance Application and the Supplemental Application for Individual Life Insurance that will be attached to and made part of this application packet.
- This entire application, which consists of this Life Insurance Application and the Supplemental Application for Individual Life Insurance, will be attached to and made part of any policy issued by American National Life Insurance Company of New York and no information about any person in the application will be considered to have been given to American National Life Insurance Company of New York unless it is stated in the application.
- I understand the agent does not have American National Life Insurance Company of New York's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this application or the policy;
- I understand that American National Life Insurance Company of New York may issue a policy different than requested in this application subject to my approval and acceptance with the exception that no change in: the amount of insurance; classification; plan of insurance; or benefits will be effective unless I have provided my written consent.
- Only the president, a vice president, or secretary of American National Life Insurance Company of New York has the authority to waive any of its rights or requirements.
- If a Conditional Receipt was not issued:
  - If there are any changes in the statements or answers given in this application between the date of application and the delivery of the policy, I am responsible for notifying American National Life Insurance Company of New York.
  - American National Life Insurance Company of New York will have no liability until:
    - A policy is issued; and
    - The first premium due is paid in full while each proposed insured is alive and in the same health as indicated in this application.
- If a Conditional Receipt was issued: I hereby certify that I have read and received the Conditional Receipt and agree to its terms.
- I acknowledge that I have received and read the Authorization to Release, Obtain and Disclose Information and authorize American National Life Insurance Company of New York to obtain personal information about me from the third-party provider(s) explained in the Authorization to Release, Obtain and Disclose Information.
- I understand that federal law requires sufficient information to identify the parties to the purchase of a policy and that failure to provide such information could result in: the policy not being issued; being delayed; unprocessed transaction requests; or policy termination.
- If the Owner is an entity, the individuals signing on behalf of the entity purchasing the policy and are authorized and empowered to individually or collectively:
  - enter into contracts and financial transactions including but not limited to the purchase of life insurance;
  - to make any subsequent withdrawals or surrenders; and
  - exercise all ownership rights under any issued policy in the entity's name.
- The entity is duly organized and existing in compliance with all laws and regulations.
- The entity will notify American National Life Insurance Company of New York in writing of a change in or revocation of authorized individuals, or any change in the entity's status that would cause any of the statements in the application to be incorrect or incomplete.
- The entity has consulted an independent tax and/or legal advisor for more information deemed necessary to understand the tax treatment of the policy.
- **I acknowledge that I have received and read the Consumer Disclosure.**

Date: Month/Day/Year Signed at: City State Country

_____ | _____ | _____ | _____

Signature of licensed agent

X _____

Print agent's name

_____

Agent's state license number

_____

Agent's company personal code

_____

Signature of primary proposed insured (Or guardian, if proposed insured is under the age of 14 1/2)

X _____

Signature of additional person proposed for insurance

X _____

Signature of additional person proposed for insurance

X _____

Signature of owner if other than proposed insured

X _____

If the owner is a corporation, partnership, or trust, title of the officer is required

_____

NF

Agent's Report

American National Life Insurance Company of New York

Mailing Address Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Phone 1-866-490-3163

1. Soliciting Agent's Report

I certify that I asked the Proposed Insured(s) each question on the application and accurately recorded each answer to me by the Proposed Insured(s).

a. How long have you personally known the proposed insured? ..... _____ Years _____ Months
b. By whom will premiums be paid? ..... ☐ Owner ☐ Applicant ☐ Other
c. If beneficiary is not a relative, explain insurable interest. _____
d. Are you aware of anything about the health, habits, hobbies, or other factors that might affect the insurability of the proposed insured? ..... ☐ Yes ☐ No
(If Yes, explain.) _____
e. Did you determine this applicant's objective and/or financial need for this insurance? *(If No, explain.)*..... ☐ Yes ☐ No
_____
f. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... ☐ Yes ☐ No
g. As agent, have you complied with state replacement regulations? ..... ☐ Yes ☐ No
h. Have you submitted paperwork for a change in reporting hierarchy or commission arrangement for this application? ..... ☐ Yes ☐ No
(If Yes, please describe change) _____ *New Upline:* _____

Dated at: City | Month/Day/Year
_____ | _____

Corporation Name: | Tax ID: | Social Security Number:
_____ | _____ | _____

Branch Office Number and PSO Code: | Agent Personal Code or Number:
_____ | _____

Licensed Agent's Signature: | Agent E-mail Address: | Telephone Number:
X _____ | _____ | _____

2. Special Issue Instructions to Administrative Office

a. Additional Policy? ..... Plan: _____ Amount: $ _____
b. Alternate Policy? ..... Plan: _____ Amount: $ _____
c. Is more than one application, or supplemental application, being submitted on proposed insured(s) to American National Life Insurance Company of New York? ..... ☐ Yes ☐ No
d. Are any other applications being submitted on the proposed insured's family members or business partners that need to be held and issued together? *(If Yes, provide names and date of birth.)*..... ☐ Yes ☐ No
_____
e. Are commissions to be split? ..... ☐ Yes ☐ No
(If Yes, and split 50/50, list both agents' names and personal code number. If Not, complete and submit the Split Credit Authorization form.)
Agent: _____ *Personal code or number:* _____
Agent: _____ *Personal code or number:* _____
f. Special Instructions: _____

3. Notes to Underwriter

_____

_____

_____

4. Requirements Ordered: See Current Underwriting Guidelines

Indicate which of the following was (were) ordered by producer, agency, or general agent:

☐ Oral Fluid Test collected by agent? Date Collected: _____ Lab ticket attached or affix barcode here: _____
☐ Automatic exam/lab requirements?

Name of approved paramed company? _____

Were medical records (APS) ordered by producer, agency or general agent? ..... ☐ Yes ☐ No
If Yes, give physician/facility's name: _____
If the medical records have been paid for, attach invoice.

AMERICAN NATIONAL

Billing Information

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

* P A C *

1. Billing Data

a. Premium Billing Mode (select one):

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ Single Premium ☐ Bi Weekly (Salary Deduction Only)

b. Premium Payment Method (select one):

☐ **Electronic Fund Transfer (EFT)** – (Choose an option below and complete Section 2)

- ☐ Draft upon approval and receipt of all outstanding policy requirements. If this option is selected, the effective date of coverage will become the draft date.
- ☐ Draft on specific day (1-28) _____, after approval and receipt of all outstanding policy requirements. Day specified will determine policy effective date.

☐ **Direct Bill (Monthly Mode not available)**

Fill in name and address where premium notices are to be sent, only if other than the owner.

Name:

Number/Street:

City: State: ZIP: Country:

☐ **Salary Deduction / Franchise / Government Allotment**

Premium amount based on Mode selected above $ _____

Payee Name: _____

Social Security Number: _____

Franchise Number: _____

c. E-mail Address of Premium Payer: _____

2. Electronic Fund Transfer (EFT) Information: Attach "VOID" Check

Name of premium payer:

Name(s) of insured(s):

Account type: ☐ Checking ☐ Savings

Bank name: Bank account number: Bank transit number:

Bank address: Number/Street City: State: ZIP:

The undersigned requests the above-named bank to honor debit entries, either by electronic or paper means, to my account and payable to American National Life Insurance Company of New York of Albany, New York. I agree that there will be no liability, on your part, for any reason whatsoever, for payment or failure to pay any such debit item. If, at any time, I do not have on deposit, in said bank, available funds sufficient to pay such debits, the pre-authorized payment privilege shall be automatically discontinued. Premiums then due or becoming due thereafter must be paid in accordance with one of the other methods of premium payment available to the policyowner. It is understood and agreed that all debit entries are accepted by the Company subject to their being honored upon presentation.

Date: Month/Day/Year

Signature of premium payer

X _____

Signature of Agent

X _____

Mailing Address:
Mail Processing Center, Life Insurance Administration, 1949 E Sunshine St, Springfield, MO 65899-0001
Business: (866) 490-3163

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? YES _____ NO _____

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? YES _____ NO _____

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? YES _____ NO _____

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? YES _____ NO _____

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? YES _____ NO _____

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? YES _____ NO _____

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

DATE	SIGNATURE OF APPLICANT	PRINTED NAME
DATE	SIGNATURE OF APPLICANT	PRINTED NAME

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:

YES _____ NO _____

DATE	SIGNATURE OF AGENT OR BROKER	PRINTED NAME

NF

Authorization to Release, Obtain and Disclose Information

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

* H I P A *

This authorization was designed to comply with the requirements of the Health Insurance Portability and Accountability Act.

I hereby authorize any physician, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, paramedical facility, other medical related facility, information database manager, insurance company, insurance support organization, health plan, group policy holder, benefit plan administrator, employer, state motor vehicle agency, other government agency, consumer reporting agency, and MIB, Inc. to provide the COMPANY, or any employee, representative, affiliate, reinsurer, independent administrator or third party acting on the COMPANY's behalf, any and all information concerning me or any proposed insured, to the extent permitted by state and federal law, including but not limited to:

- entire medical record and any other protected health information;
- diagnosis or treatment of any physical, behavioral or mental condition;
- diagnosis or treatment of any mental illness (excluding psychotherapy notes);
- consultations, surgeries, hospitalizations or confinements;
- HIV, AIDS or ARC related information, including test results;
- serious communicable diseases or infections, including sexually transmitted diseases;
- drug, alcohol or tobacco use;
- consumer reports, including investigative consumer reports;
- driving records; and
- finances, occupations or avocations.

This authorization permits information to be provided electronically, including use of an electronic interchange through a health information exchange, or by access directly to an electronic health record system.

I hereby authorize the COMPANY and its reinsurers to make a brief report of my information to MIB, Inc. I understand that the COMPANY may use or disclose such information to any employee, representative, affiliate, reinsurer, independent administrator or third party for the performance of certain insurance functions including but not limited to underwriting, policy service, claims administration, and compliance; in response to subpoenas or summons; or as otherwise required or permitted by law.

I further understand that:

(1) I may refuse to sign this authorization and my refusal to sign will affect my ability to obtain life insurance coverage;

(2) Health care providers or health plans cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization;

(3) Any agreement to restrict information concerning me or any proposed insured does not apply to this authorization;

(4) Once information is disclosed under this authorization, it may be redisclosed and no longer be subject to certain state and federal laws;

(5) A copy of this authorization is as valid as the original;

(6) I may request a copy of this authorization;

(7) I may inspect or copy any information used or disclosed under this authorization;

(8) This authorization is valid from the date signed for a duration of 24 months. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the COMPANY's Service Center, Attn: Life New Business, Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408.

Name of Proposed Insured	X Signature of Proposed Insured	Date of Birth	Date
_____	X_____	_____	_____

☐ Check here if you are signing as the parent, guardian or authorized representative of the proposed insured.

AGENT: EACH PROPOSED INSURED MUST SIGN A SEPARATE AUTHORIZATION.

Supplemental Application for Individual Life Insurance

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

* S U P *

Product Selections

Individual Nonparticipating Flexible Premium Adjustable Life Insurance Product with a No-lapse Guarantee

Please select the plan applied for below:

■ Signature Guaranteed Universal Life

Amount of Insurance $ _____
(Minimum of $25,000)

Life Insurance Qualification Test:

☑ *Cash Value Accumulation Test ("CVAT")*

Death Benefit Option

■ Option A - Specified Amount

Duration of Death Benefit Guarantee

☐ Coverage to 95 ☐ Coverage to 100

☐ Coverage to 105 ☐ Coverage to 121 ☐ Other Age _____

Optional Riders / Benefits *(Additional costs may apply.)*

☐ Children's Level Term Rider ..... $ _____
Complete Section 9 of Application.

☐ Disability Waiver of Stipulated Premium Rider ..... $ _____

IMPORTANT NOTICE: The Disability Waiver of Stipulated Premium Rider does not guarantee that the policy to which it is attached will not lapse. If the Stipulated Premium to be waived does not maintain a surrender value sufficient to satisfy the monthly deductions, the policy will lapse in accordance with the policy's grace period provision.

The Following Riders Will Be Added Automatically to Qualifying Policies

Guaranteed Cash Out Rider

There is no charge for this rider; however, your policy must meet an annual qualification test in order to retain the rider. The annual qualification test is explained in the rider.

Accelerated Death Benefit Rider for Terminal Illness

NOTICE: Receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. The plan of insurance applied for may contain an Accelerated Death Benefit rider. There is no additional premium charged for this rider; however, if this rider is exercised, an administrative charge, not to exceed $500, may be applied. A discount method is used to calculate the acceleration payment.

Accelerated Death Benefit Rider for Chronic Illness

NOTICE: Receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. The plan of insurance applied for may contain an Accelerated Death Benefit rider. There is no additional premium charged for this rider; however, if this rider is exercised, an administrative charge, not to exceed $500, may be applied. A discount method is used to calculate the acceleration payment.

This Supplemental Application will be attached to and made part of any policy issued.

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Premium

Planned Periodic Premium to a Specified Age: $ _____

☐ Premium to 95 ☐ Premium to 100 ☐ Premium to 105 ☐ Premium to 121 ☐ Other Age_____

Planned Premium Amount.....$ _____

Initial Premium Amount (if different than Planned Periodic Premium Amount) .....$ _____

☐ *Check here if initial premium will be applied from a 1035 Exchange.*

Special Requests

Special Dating Instructions: Issue Age _____ Issue Date _____

Important Notice

This policy will pay the specified death benefit so long as the planned premium payment is made for the duration selected at issue. Policy loans, withdrawals, or flexible premium payments differing from the planned periodic premium may result in policy lapse.

This Supplemental Application will be attached to and made part of any policy issued.

Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947 Business: (866) 490-3163
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408

NOTICE AND CONSENT FOR
BLOOD OR OTHER BODY FLUID TESTING WHICH MAY INCLUDE AIDS RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extacted from cheek and gum tissue or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. Positive HIV and hepatitis antibody/antigen tests will be reported to your State Department of Health if the laboratory or the insurance company are required or permitted to do so by law.

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NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

NAME AND ADDRESS OF PHYSICIAN FOR REPORTING A POSSIBLE POSITIVE TEST RESULT:

_____

_____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: _____.The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

_____

_____

The result will be sent to that person by registered mail with restricted delivery.

The department of health's statewide toll-free telephone number that may be called for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services: 1-800-541-AIDS

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and a variety of other bodily fluids and secretions of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Testing. I voluntarily consent to the collection of blood, oral fluid from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____

Signature of Proposed Insured or Parent/Guardian

_____

Date Signed (Month/Day/Year)

_____

Name of Proposed Insured (Print)

_____

Address

Supplemental Application for Chronic Illness

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mailing Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

1. Does the insured have any accelerated benefit riders through a life insurance policy or any long-term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance, or coverage in the New York Partnership for Long Term Care Program? ☐ Yes ☐ No
   If yes, please list the existing coverages:

   _____

   _____

   _____

2. Is the applied for Accelerated Benefit Rider for Chronic Illness intended to replace any existing accelerated benefit riders provided through a life insurance policy? ☐ Yes ☐ No

   If Yes,

   Carrier: _____ Coverage Type: _____

   Policy Number: _____ Owner: _____

   Amount: $ _____

3. Is the applied for Accelerated Benefit Rider for Chronic Illness intended to replace any existing Long Term Care Insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance, or coverage in the New York Partnership for Long Term Care? ☐ Yes ☐ No

I have reviewed the current coverage of the applicant and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant's needs.

All statements and answers to the above questions are complete and true to the best of my knowledge and belief, and shall form part of my application.

_____ _____
Signature of Agent Date

_____ _____
Signature of Insured Date

For any questions requiring details, attach an additional sheet of paper, if necessary.

USA Patriot Act Notification and Customer Identification Verification

American National Life Insurance Company of New York
344 Route 9W, Glenmont, NY 12077

Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947 Business: (866) 490-3163
Mail Processing Center, Life Insurance Administration
1949 E. Sunshine St., Springfield, MO 65899-0001

1. Client Name _____ **Application / Policy / Contract Number** _____

Source of Funds ☐ W-2 Wages ☐ Investments ☐ Social Security or Pension ☐ Savings
☐ Another insurance policy / annuity contract ☐ Other (please explain) _____

USA PATRIOT Act Notice – *to be read by or to customer.*

2. The USA PATRIOT Act requires that We establish an Anti-Money Laundering ("AML") Program, notify customers that We must verify the identity of the owner(s) of our contracts, and collect documents and information sufficient to provide such verification. You should know that failure to provide the requested identification will result in delays in the issuance of the requested coverage and may result in a decision not to accept your business.

Customer Identification Verification: In order to satisfy such obligations, We require our representative to review and verify a current government issued photo ID for each Owner/Trustee/Partner associated with a contract. Information on such identification must be recorded below. We may use third party sources to verify the information provided.

a. **Identification Verified** (One for each Owner/Trustee/Partner. Use additional forms if necessary.)

Owner/Trustee/Partner
Check one form of ID:
☐ Driver's license
☐ Resident Alien ID (Green Card)
☐ Passport
☐ Other: (Describe) _____

Joint Owner/Trustee/Partner
Check one form of ID:
☐ Driver's license
☐ Resident Alien ID (Green Card)
☐ Passport
☐ Other: (Describe) _____

The following information should be recorded exactly as it appears on the identification reviewed

Name _____ Date of Birth _____	Name _____ Date of Birth _____
Street Address (not PO Box) _____	Street Address (not PO Box) _____
City, State, Zip _____	City, State, Zip _____
Number on ID _____ State or Country _____	Number on ID _____ State or Country _____
Identification Expiration Date _____	Identification Expiration Date _____

b. Entity Verification: Check the appropriate entity as listed below and submit copies of documentation viewed to gain first-hand knowledge of the existence of a legitimate business. If the Owner is a minor or non-legal entity, review the identification of the individual who submits an application on behalf of the minor or non-legal entity.

☐ **Corporation, LLC, professional association, or professional corporation:** Articles of Incorporation, Organization or Association or similar document filed in the state in which the entity is formed
☐ **Limited Partnership:** Certificate of Limited Partnership or similar document filed in the state where the partnership is formed
☐ **General Partnership or Joint Venture:** Agreement, Joint Venture Agreement or similar agreement governing the formation and operation of the partnership
☐ **Trust and All Other Entities:** Document governing the formation and operation of the entity

3.
☐ I certify that I personally met with the proposed Owner(s)/Trustee(s)/Partners and reviewed the above identification document. To the best of my knowledge, it accurately reflects the identity of the proposed Owner(s)/Trustee(s)/Partners.
☐ I was unable to personally review the identification documents for the reason stated below. I certify that, to the best of my knowledge, the information provided by the Owner(s)/Trustee(s)/Partners is true and accurate.

Reason for not reviewing documents _____

Note: Failure to personally review the identification documents will result in processing delays in order to verify customer identity and may result in a decision not to accept the business.

Representative Name _____ Personal Code _____

Representative Signature _____ Date _____

Verification of Sales Material

American National Life Insurance Company of New York

Mailing Address Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Phone 1-866-490-3163

* A N Y 2 4 *

1 Applicant Information

Applicant Name

_____

2 Sales Material

Other than the required Product Disclosure, please indicate below all sales material used with the client in the sale of this contract. If an item is not listed, a copy of it should be submitted with the application.

Annuities

ASIA PLUS 7 Annuity–NY
- ☐ Brochure (Form ANY-10773)
- ☐ EIA Disclosure (Form ANY-208)
- ☐ Rate Lock Procedure (Form ANY-10789)
- ☐ Illustration

ASIA PLUS 10 Annuity–NY
- ☐ Brochure (Form ANY-10774)
- ☐ EIA Disclosure (Form ANY-208)
- ☐ Rate Lock Procedure (Form ANY-10789)
- ☐ Illustration

WealthQuest Citadel 5 Diamond Annuity–NY
- ☐ Brochure (Form 10593)
- ☐ Illustration

WealthQuest Citadel 7 Diamond Annuity–NY
- ☐ Brochure (Form 10597)
- ☐ Illustration

Palladium Multi-Year Guarantee Annuity–NY
- ☐ Brochure (Form 4884)
- ☐ Illustration

Palladium Immediate Annuity–NY
- ☐ Brochure (Form 10273)
- ☐ Illustration

Century Plus Annuity–NY
- ☐ Brochure (Form 11011)
- ☐ Illustration

Life Insurance

Signature Guaranteed Universal Life Insurance–NY
- ☐ Brochure (Form 10801)
- ☐ Preliminary Information

Signature Indexed Universal Life Insurance–NY
- ☐ Brochure (Form 10694)
- ☐ Equity Indexed Disclosure (Form ANY-72)
- ☐ Illustration

Signature Whole Life Insurance–NY
- ☐ Brochure (Form 10916)
- ☐ Illustration

3 Other Sales Material

If any other sales material used, please list:

_____

_____

_____

_____

4 Signatures

I verify that all sales material used in the sale and writing of this application is contained in the above list, that copies of any sales material used but not listed above are attached and if a replacement, is within American National Life Insurance Company of New York's written position with respect to the acceptability of replacements.

_____ _____

Agent Name **Agent Code**

x _____ _____

Signature of Agent **Date:** Month / Day / Year

AMERICAN NATIONAL

Consumer Disclosure

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

* M I B *

MIB / FCRA PRE-NOTIFICATION

AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED(S).

MIB, Inc. Pre-Notification

Information regarding your insurability will be treated as confidential. The American National Life Insurance Company of New York or its reinsurer(s), however, may make a brief report of such information to the MIB, Inc. (MIB). MIB is 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 company, MIB will supply such company with information in your file upon request.

At your request, MIB will arrange disclosure of information in your file. If you question the accuracy of such information, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. MIB's telephone number is 866-692-6901 (TTY 866-346-3642), and its mailing address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The American National Life Insurance Company of New York or its reinsurer(s) may also release information in your file to other insurance companies to whom you apply for life or health insurance coverage or to whom a claim for benefits is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Report Act Pre-Notification

We may request a consumer report, including an investigative consumer report, in connection with this application for insurance. In addition, such a report may be requested in the future to update our records or if you apply for additional coverage. The report may include information about your character, general reputation, personal characteristics or mode of living and may involve personal interviews with neighbors, friends, employers, business associates, financial sources, friends, neighbors or others with whom you are acquainted.

You have the right to request a written summary of your rights under the federal Fair Credit Reporting Act. You also have the right to make a written request within a reasonable period of time for a complete and accurate disclosure regarding the nature and scope of the requested investigation. Upon written request, we will disclose whether an investigative consumer report was requested as well as the name and address of the consumer reporting agency to whom the request was made. By contacting the agency, you may inspect and receive a copy of the report.

AMERICAN NATIONAL

Summary and Disclosure Notice for Accelerated Death Benefit Riders

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mailing Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE ACCELERATED Death Benefit RIDERS. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THESE RIDERS.

Important Notices for the Accelerated Death Benefit Rider for Chronic Illness:

Notice to Buyer: This Accelerated Death Benefit Rider for Chronic Illness may not cover all of the costs associated with Chronic Illness of the Insured. The buyer is advised to carefully review the Rider benefits.

This product is a life insurance policy that accelerates the Death Benefit on account of Chronic Illness and is not a health insurance policy providing long-term care insurance subject to the minimum requirements of New York Law, does not qualify for the New York State Long-Term Care Partnership program, and is not a Medicare supplement policy.

Your Policy may contain one or both of the Accelerated Death Benefit Riders described in this summary and disclosure notice. You should check Your Policy to determine which, if any, of these Riders have been attached to Your Policy. In order for a Policy to be eligible for the Terminal Illness Rider, there must be a minimum of $25,000 total Death Benefit; in order for a Policy to be eligible for the Chronic Illness Rider, there must be a minimum of $50,000 total Death Benefit. If You accelerate the Death Benefit, You will not receive the full Death Benefit, but rather a reduced amount called the Accelerated Death Benefit Payment.

You may request a full or partial Accelerated Death Benefit. Payment of a full Accelerated Death Benefit means that Your Base Policy or Covered Rider(s), for which the full Accelerated Death Benefit is paid, will terminate and the Death Benefit that would have been paid to the Beneficiary after the death of the Insured will be paid to You prior to the death of the Insured. If You request a partial Accelerated Death Benefit, then all coverages eligible for acceleration will be reduced by the percentage of Accelerated Death Benefit requested. A portion of the Death Benefit that would have been paid to the Beneficiary after the death of the Insured will be paid to You prior to the death of the Insured.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children, and Supplemental Security Income. Receipt of Accelerated Death Benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policy owners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

The Accelerated Death Benefit Rider Chronic Illness is designed to be tax favorable; however, receipt of Accelerated Death Benefits may be taxable depending on the specific circumstances. Prior to applying for such benefits, policy owners should seek assistance from a qualified tax adviser.

No health care facility (general hospitals, residential health care facilities, diagnostic and treatment centers and clinics) can require You to accelerate Your Death Benefit as a condition of admission to such health care facility or for providing any care in such facility.

Other means may be available to achieve the intended goal, including a policy loan.

In order to receive Accelerated Death Benefits, You must request the payment of a full or partial Accelerated Death Benefit and show proof that the Insured has met the qualifying conditions of one of the Accelerated Benefit Riders, as defined below.

There is no additional premium required for this Rider.

An administrative charge, not to exceed $500, will be deducted from the Accelerated Death Benefit Payment.

Accelerated Death Benefit – The portion of the Eligible Death Benefit payable in part or in full that You elect for acceleration. Subject to the terms of these Riders, We will pay You an Accelerated Death Benefit during the lifetime of an Insured, upon proof that the Insured has been diagnosed with a Terminal or Chronic Illness. The Accelerated Death Benefit will be paid in lieu of all or a portion of the Eligible Death Benefit.

Terminal Illness – An illness that results in the Rider Insured having a life expectancy of 12 months or less, that was first diagnosed on or after the Base Policy's Issue Date.

Chronic Illness – Diagnosis by a Licensed Health Care Professional as having a Chronic Illness requiring continuous care in an eligible facility or at home for the remainder of the Rider Insured's lifetime. A Chronic Illness is an illness or physical condition in which the Rider Insured:

a) is unable to perform at least two of the six Activities of Daily Living defined below, without Substantial Assistance from another person for a period of at least 90 days, due to a loss of functional capacity; or

b) requires substantial supervision by another person to protect the Rider Insured from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living:

a) Bathing - including washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower;

b) Continence - the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag;

c) Dressing - the ability to put on and take off all items of clothing and any necessary braces, fasteners, or artificial limbs;

d) Eating - the ability to feed oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously;

e) Toileting - the ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;

f) Transferring - the ability to move into and out of a bed, chair, or wheelchair.

Substantial Assistance. Hands-on or stand-by assistance.

a) Hands-on assistance means the physical assistance of another person without which the Rider Insured would be unable to perform an Activity of Daily Living;

b) Stand-by assistance means the presence of another person within arm's reach of the Rider Insured that is necessary to prevent, by physical intervention, injury to the Rider Insured while the Rider Insured is performing an Activity of Daily Living such as being ready to catch the individual if he or she falls while getting into or out of the bathtub or shower while bathing, or being prepared to remove food from the individual's throat if he or she chokes while eating.

Severe Cognitive Impairment. The deterioration or loss of intellectual capacity that is:

a) comparable to, and includes, Alzheimer's Disease and similar forms of irreversible dementia; and

b) measured by clinical evidence and standardized tests which reliably measure impairment in:

1) short-term or long-term memory;
2) orientation to people, places, or time;
3) deductive or abstract reasoning;
4) judgment as it relates to safety and awareness.

If We determine benefits are payable under this Rider, We will send You a Claim Form that will show the Eligible Death Benefit available for acceleration and allow You to elect a full or partial acceleration. The Claim Form must be completed and signed by You, and any Assignee and/or Irrevocable Beneficiary within 30 days of the Claim Form Date. It must be returned to Us in order to accelerate the benefit. We may require that You return Your Base Policy to Our Administrative Office.

Within 5 days following Our receipt of the completed Claim Form, We will send You an Illustration demonstrating:

(1) the amount of the Eligible Death Benefit that has been requested to be accelerated and the amount Accelerated Death Benefit payment;

(2) the Death Benefit that would be payable to the Beneficiary upon the Insured's death under the policy if there was not an acceleration; and;

(3) the impact the acceleration of the Death Benefit will have on the cash value, Death Benefit, and policy loans of the Base Policy or Covered Rider(s). All expenses and interest charges associated with accelerating the Death Benefit will be shown.

We are prohibited from paying the Accelerated Death Benefit Payment for 5 days from the date We provide the Illustration. You may rescind Your request at any time before You receive the Accelerated Death Benefit Payment.

The Accelerated Death Benefit will be paid to You in lieu of all or a portion of the Death Benefit. The Eligible Death Benefit is the total amount of Death Benefit available for acceleration under the Base Policy and any Covered Rider(s). The Accelerated Death Benefit Payment will be equal to the Accelerated Death Benefit requested less the actuarial discount, as determined by Us; an administrative charge not to exceed $500; and a pro rata portion of any policy debt, if the Insured is also the Base Policy Insured. The Accelerated Death Benefit Payment for the Base Policy Insured will never be less than the surrender value of the Base Policy, if any. If the Policy does not have any cash value, then it is possible for the Accelerated Death Benefit Payment to be zero.

You may choose to receive the Accelerated Death Benefit Payment in a lump sum or a series of installments. If You elect installments, You may choose to receive payments quarterly, semi-annually or annual and each payment must be at least 25% of the Accelerated Death Benefit Payment.

If a Full Acceleration of the Death Benefit is elected for the Base Policy Insured, any Rider(s) attached to the Base Policy will be treated as if the Base Policy Insured has died. Acceleration of a Covered Rider(s) will be treated as though the Insured has died for the purpose of determining the impact of the acceleration on the Base Policy.

For an acceleration due to a Chronic Illness, We will not pay You more than the annual calculation of the per diem limitation in effect under IRC Section 7702(B)(d) on behalf of a Covered Insured during a calendar year. The annual per diem amount for 2016 is $124,100.

Generic Accelerated Death Benefit Demonstration for Terminal Illness. The hypothetical demonstration below shows the effect of an Accelerated Death Benefit Payment on a policy. This example assumes a partial Accelerated Death Benefit request of $250,000 at age 55 on a policy issued to a Male Standard Nicotine Non-User, issue age 45, with a $500,000 specified amount. This demonstration assumes that the policy loan interest rate is equal to 8% (in arrears).

Partial Accelerated Death Benefit Request:	$ 250,000
Actuarial Discount:	$ 18,519
Policy Debt X Reduction Percentage:	$ 6,000
Administrative Charge:	$ 250
Amount Paid to Policy Owner:	$ 225,231

Policy Values Immediately Before Acceleration		Policy Values Immediately After Acceleration		Policy Values 12 Months After Acceleration	
Specified Amount	$500,000	Specified Amount	$250,000	Specified Amount	$250,000
Annual Premium	$4,000	Annual Premium	$2,000	Annual Premium	$2,000
Account Value	$30,000	Account Value	$15,000	Account Value	$16,620
Policy Surrender Value(1)	$22,000	Policy Surrender Value(1)	$11,000	Policy Surrender Value(1)	$13,659
Policy Loan Balance(2)	$12,000	Policy Loan Balance(2)	$6,000	Policy Loan Balance(2)	$6,480
Death Benefit Payable(3)	$488,000	Death Benefit Payable(3)	$244,000	Death Benefit Payable(3)	$243,520
Available Surrender Value(4)	$10,000	Available Surrender Value(4)	$5,000	Available Surrender Value(4)	$7,179

Generic Accelerated Death Benefit Demonstration for Chronic Illness. The hypothetical demonstration below shows the effect of an Accelerated Death Benefit Payment on a policy. This example assumes a partial Accelerated Death Benefit request of $250,000 at age 55 on a policy issued to a Male Standard Nicotine Non-User, issue age 45, with a $500,000 specified amount. This demonstration assumes that the policy loan interest rate is equal to 8% (in arrears).

Partial Accelerated Death Benefit Request:	$	250,000
Actuarial Discount:	$	192,647.49
Policy Debt X Reduction Percentage:	$	6,000
Administrative Charge:	$	250
Amount Paid to Policy Owner:	$	51,102.51

Policy Values Immediately Before Acceleration		Policy Values Immediately After Acceleration		Policy Values 12 Months After Acceleration	
Specified Amount	$500,000	Specified Amount	$250,000	Specified Amount	$250,000
Annual Premium	$4,000	Annual Premium	$2,000	Annual Premium	$2,000
Account Value	$30,000	Account Value	$15,000	Account Value	$16,620
Policy Surrender Value(1)	$22,000	Policy Surrender Value(1)	$11,000	Policy Surrender Value(1)	$13,659
Policy Loan Balance(2)	$12,000	Policy Loan Balance(2)	$6,000	Policy Loan Balance(2)	$6,480
Death Benefit Payable(3)	$488,000	Death Benefit Payable(3)	$244,000	Death Benefit Payable(3)	$243,520
Available Surrender Value(4)	$10,000	Available Surrender Value(4)	$5,000	Available Surrender Value(4)	$7,179

Notes:

(1) Policy Surrender Value displayed is prior to any reduction for Policy Loan Balance.

(2) Policy Loan accumulates interest at an 8% (in arrears) annual interest rate in this example.

(3) Death Benefit Payable is equal to the Specified Amount reduced by the Policy Loan Balance.

(4) Available Surrender Value is the amount available for full surrender, additional loans, or partial withdrawals. The Available Surrender Value is the excess (if any) of the Policy Surrender Value over the Policy Loan Balance.

(5) $25,000 must remain after a Partial Acceleration.

I acknowledge that I have reviewed this Summary and Disclosure Notice for Accelerated Death Benefit Riders and have been provided a copy for my records.

_____ _____

Owner Date

_____ _____

Agent Date

Disclosure Statement for Signature Guaranteed Universal Life Insurance—NY (Client Copy)

American National Life Insurance Company of New York

Mailing Address Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Phone 1-866-490-3163

* D S C *

Agent, please review the following information carefully with your client. Sign and return the attached insurance agent's acknowledgment with the completed application. Please leave a complete copy of this disclosure with the client.

This Disclosure Statement is not intended to be a complete explanation of your policy. Please read your policy carefully for more complete details.

Thank you for considering American National Life Insurance Company of New York's ("the Company") Signature Guaranteed Universal Life. We want to make sure you understand its features and benefits.

Signature Guaranteed Universal Life insurance is designed to provide insurance protection on the life of the insured person to a specified age from 95 to 121, as long as the premiums are paid as scheduled.

If you have questions about your life insurance policy, please contact your insurance agent or a company representative at 1-866-490-3163.

Important Life Insurance Policy Roles Under This Policy

The Owner
The person who has the authority to exercise all rights and privileges under the Policy, such as changing the beneficiary. Also referred to as the Policyholder.

The Insured
The person on whom the policy is purchased and the one upon whose death the Death Benefit will be paid. The Insured has no ownership rights under the policy unless the Insured is also the Owner.

The Beneficiary
The person or entity who will receive the policy Death Benefit upon the death of the Insured. The Beneficiary is designated by the Owner. A Beneficiary may be designated as primary (first) or contingent (alternate to the primary beneficiary). A Beneficiary can be revocable or irrevocable. An irrevocable Beneficiary must provide written permission to be removed as Beneficiary and may have the right to approve or deny other policy changes.

Types of Universal Life Insurance Offered by the Company

Signature Guaranteed Universal Life Insurance is a non-participating policy with a 10-year Minimum Premium Guarantee and a No Lapse Guarantee Account (NLG). It provides a guaranteed level death benefit to a specified age selected at time of application, as long as all planned premiums are paid as scheduled. It offers a Guaranteed Cash Out Rider, at no additional cost, which provides the opportunity for a full or partial return of the premiums paid if the policy is fully surrendered on the 15th, 20th or 25th policy anniversary. Signature Guaranteed Universal Life has a minimum face amount of $25,000 and can be issued to an Insured age 18 to age 80 (age 75 for a nicotine user).

Benefits and Limitations of This Policy

▶ Benefits:

- The death benefit is guaranteed to the age selected at time of application (attained ages 95 to 121), as long as all planned premiums are paid as scheduled and policy loans or partial withdrawals are not taken.
- The policy will not lapse during the 10-Year Minimum Premium Guarantee period, even if it does not have enough surrender value to cover the monthly deductions, if the minimum premium requirement is paid. (Additional premiums may be required if you take a loan or withdrawal during this period.)
- After the 10th policy anniversary, the policy will not lapse if the NLG Account is greater than or equal to zero, even if the policy does not have enough surrender value to cover the monthly deduction. (Additional premiums may be necessary to keep the NLG Account positive.)
- The tax-deferred cash value of the policy will build over time at a declared interest rate, which is guaranteed to never be less than the Minimum Guaranteed Interest Rate (MGIR) determined at issue.
- Policy loans from the accumulated value are generally tax fee.

▶ Limitations:

- During the 10-Year Minimum Premium Guarantee period, the policy will lapse when both the minimum premium requirement is not satisfied and the surrender value becomes negative due to a withdrawal or unpaid loan. If the policy lapses and is reinstated during the 10-Year Minimum Premium Guarantee period, this guarantee will be permanently lost.
- The NLG Account will not prevent policy lapse if there is an outstanding loan. An outstanding loan will result in a policy lapse if the surrender value is not sufficient to cover monthly deductions. If the policy lapses and is reinstated, this provision will be permanently lost.
- When a policy loan is taken, the cash value and available loan value are each reduced by the amount of the loan. Policy loans accrue daily interest at a rate declared by the Company. If the loan is not repaid, the amount of the loan will increase over time. Unpaid policy loan interest may cause the policy to permanently lapse.
- If your policy lapses, any withdrawals you have received may be taxable.
- Increases in the policy's face amount are not permitted.
- This policy is not intended to build accumulation value.
- The Company will not pay the death benefit and will return all premiums paid if the Insured commits suicide within two years of policy issuance.
- For a period of 2 years after the policy is issued, the company has the right to contest the policy and/or deny a claim if the applicant makes a material misrepresentation in the application.
    - **Conversions**
      If the policy is issued as a conversion without an increase in coverage, the incontestability period is measured from the original policy's issue date and does not begin anew. If additional coverage is added, and such coverage requires evidence of insurability, the incontestability period for the additional amount of coverage will be effective as of the new policy's issue date.
    - **Reinstatements**
      If the policy is reinstated, the incontestability period is measured from the date of reinstatement and any contest by the Company may only be based on material misrepresentations contained in the application for reinstatement.
    - **Riders**
      If a rider is added after the policy is issued, the incontestability period for the rider is measured from the date the rider is issued.

Premiums, Fees and Other Charges

▶ Premiums:

- **Planned Periodic Premium**
  The amount required to guarantee the death benefit to the customized duration you selected. This amount satisfies the premium requirements for both guarantee provisions in the policy and the Guarantee Cash Out Rider.
- **Unscheduled Additional Premiums**
  Additional premiums may be paid at any time before the policy Maturity Date. The total premium amount shall not exceed an amount that will disqualify this policy as life insurance.
- **Net Premiums**
  Any premium received, whether Planned Periodic Premiums or Unscheduled Additional Premiums will be reduced by a percentage of premium charge, not to exceed the maximum shown in the Data Section of the policy. The resulting premium is called the Net Premium.

Premiums shall be paid in advance and may be paid at any time while the policy is in force until the policy anniversary coinciding with the Insured's attained age of 121. The Owner may request a change in the method or frequency of the payments while the policy is in force by submitting a request in writing to the Company. The actual amount, timing, and frequency of premium payments will affect the accumulation value, 10-Year Minimum Premium Guarantee, NLG Account, and duration of insurance coverage. If the total premiums paid exceed the limitations of the Internal Revenue Code, the amount of excess premium will be returned to the Owner.

▶ Monthly Deductions:

A monthly deduction is taken from the accumulation value each calendar month in an amount equal to:

- The Monthly Expense Fee shown in the policy's Data Section; plus
- A Monthly Expense Charge that varies by issue age, gender, rate class and band; plus
- A Cost of Insurance Charge incurred to the Insured's attained age of 121; plus
- The monthly charge for any additional riders.

Please review your policy for more detail regarding Monthly Deductions.

▶ Other:

- Interest is charged on any loans that are taken.
- A fee is charged on any partial surrenders taken.

Policy Loans

The policy cash value will build over time and be available to borrow subject to the limitations described in the policy. Policy loans accrue daily interest at a rate declared by the Company. At death, any unpaid loan balance would be deducted from the benefits payable, thus providing less for the named beneficiaries.

If a loan is outstanding while the policy is in force, the NLA Account will not prevent policy lapse. The amount of a loan and unpaid interest will be deducted from the total amount of premiums paid to determine if the 10-Year Minimum Premium requirement has been satisfied.

The maximum Policy Loan amount cannot exceed the policy's surrender value at the end of the current policy year.

The Company reserves the right to defer payment of any loan for up to six months except when the Loan is made to pay premium due.

Death Benefit

Upon the death of the Insured, payment of the Death Benefit will be equal to the greater of:

- The policy's specified amount; or
- Minimum death benefit calculated by the Cash Value Accumulation Test

The Death Benefit will be reduced by the amount of any outstanding policy debt.

The Death Benefit may be subject to any adjustments provided in the Misstatement of Age or Gender, Incontestability, and Suicide provisions.

Policy Termination and Reinstatement

Termination
The policy will terminate on the first to occur of: 1) the Insured's death; 2) the expiration of the grace period; 3) full surrender; 4) excess policy debt (this occurs when a policy loan plus interest exceeds the cash value of the policy); (5) the policy reaches its maturity date, ages 95 to 121.

Lapse
A grace period of 61 days is provided for the payment of each premium. The policy will remain in force during the grace period. The policy will lapse at the end of the grace period if the premium due is not received.

Reinstatement
The policy may be reinstated within three years of the date of termination, if termination was due to the expiration of the grace period. Reinstatement requires:

- An application for reinstatement;
- Satisfactory evidence of insurability of the Insured;
- A payment equal to:
  - **a.** The amount of any Accumulation Value less the Surrender Charge, on the date of lapse, if any; plus
  - **b.** Two times the last Monthly Deduction amount when the Policy was In-force; plus
  - **c.** The amount to repay or restore Policy Debt, if any.

Upon approval of the request for reinstatement, the policy will be reinstated as of the next monthly deduction date. After reinstatement, any unpaid policy debt will be the same as the amount of policy debt on the date of termination, and the cost of insurance will restart at the current age and policy duration on the date of reinstatement.

The following policy benefits will **NOT** be reinstated:

- Any Guaranteed Cash-Out Rider that was in force on the date of policy termination
- The No Lapse Guarantee
- The 10-Year Minimum Premium Guarantee

Policy Surrender

While the policy is in force, the Owner may surrender the policy for any Surrender Value by sending a written request to the Company. The Surrender Charge varies by policy year according to the Schedule of Surrender Charges shown in the Data Section of your policy.

At time of the surrender, the Surrender Value is equal to 1) the Accumulation Value; less 2) any policy debt; less 3) a Surrender Charge, if applicable.

The Owner may partially surrender the policy by sending a written request to the Company for a minimum Partial Surrender amount of $250. A Partial Surrender will reduce the Accumulation Value by the sum of 1) the amount of the Partial Surrender; plus 2) a $25 Partial Surrender fee.

A policy surrender is subject to the rights of any assignment. Further, the Company may delay payment of any cash value for up to six months after the date we receive your request. If We delay payment for more than ten working days after the written request to surrender is received, interest will be paid at a rate equal to the rate for proceeds left on deposit with Us, on the Surrender Value from the date We received the written request; unless such interest is for an amount less than $25.

Settlement Options

The Owner can surrender the policy and apply all or part of the Surrender Value to an Annuity Option or all or part of the Accumulation Value upon the Maturity Date to an Annuity Option.

A Beneficiary can apply all or part of the Death Benefit to an Annuity Option. The settlement options include several annuity options. Election of an Annuity Option may be made by the Owner if the Insured is living, or by the Beneficiary if the Insured is not living; and there is no Annuity Option in effect. The minimum amount applied to an Annuity Option is $5,000.

Please review your policy for more detail regarding Annuity Options.

Taxes

▶ How will the death benefit from my guaranteed universal life policy be taxed?

Generally, the life insurance proceeds paid to your beneficiary are not includable in the beneficiaries' gross income and are received free from income tax.

The Company and its agents are not authorized to give tax or legal advice. Consult your tax advisor or tax attorney for your specific circumstances.

Riders

▶ The policy includes a Guaranteed Cash-Out Rider and two accelerated benefit riders at no additional cost:

1. The **Guaranteed Cash-Out Rider** provides the opportunity to access an enhanced cash benefit during the 60-day period following the 15th, 20th, or 25th policy anniversary for a partial or full return of the premiums paid upon full surrender of the policy. Other terms and conditions apply. Please see rider form for details. Policy Form GCOR15(NY).
2. The **Terminal Illness Accelerated Death Benefit Rider** provides for the payment of an accelerated benefit if an eligible insured has an illness or chronic condition that is expected to result in Death Within 12 Months. Other terms and conditions apply. Please see rider form for details. Policy Form ABR14-TM(NY).
3. The **Chronic Illness Accelerated Death Benefit Rider** provides for the payment of an accelerated benefit if an eligible insured is unable to perform two out of six Activities of Daily Living (2 of 6 ADLs) or experiences severe cognitive impairment. Please note that it may not be advisable to request an accelerated death benefit for chronic illness unless the insured's qualifying conditions is expected to have a significant negative impact on the insured's life expectancy. Other terms and conditions apply. Please see rider forms for details. Policy Forms: ABR14-TM(NY); ABR14-CH(NY).

► **Other riders are available subject to the payment of additional premium:**

1. The **Disability Waiver of Stipulated Premium** will waive the stipulated planned policy premium in the event of total disability, which lasts for at least six consecutive months. Waived premiums are considered to be paid premiums and are credited to the policy. This amount may not keep the policy active to the policy maturity date. Terms and conditions apply. Please see rider form for details. Policy ULDW10(NY).
2. The **Children's Term Rider** insures each child approved when the policy is issued, and any subsequent children born or adopted while the rider is in force. The coverage expires on each child when they attain age 25 or the policy anniversary following the Insured's attained age of 65, at which time the coverage may be converted to a permanent plan of insurance currently offered by the company for conversion without evidence of insurability. Policy form ULCTR14(NY).

Additional Information

► **What else do I need to know?**

- We pay the insurance agent a commission for selling the life insurance policy to you.
- The Owner may cancel the policy for a full refund of all premium paid by returning the policy with a written request for a full refund no later than 30 days after the life insurance policy is delivered. Read your policy to learn about the Notice of a 30-Day Right to Cancel Policy. If the life insurance policy purchased replaces other life insurance, the right to examine period expires sixty (60) days after the new policy is delivered.
- You can obtain general information regarding life insurance from the NAIC Life Insurance Buyer's Guide your agent provided to you. To request an additional copy, contact the Company at 1-866-490-3163.

► **NOTE: This Disclosure Statement is not intended to be a complete explanation of your policy. Please read your contract carefully for more complete details. If you have any questions about this policy, please contact your insurance agent or a company representative at 1-866-490-3163.**

Disclosure Statement for Signature Guaranteed Universal Life Insurance—NY (Insurance Agent's Acknowledgement)

American National Life Insurance Company of New York

Mailing Address Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Phone 1-866-490-3163

* D S C *

Insurance Agent's Statement

I certify that:

- I have reviewed the Disclosure Statement with the Owner and informed the owner of the features of the policy and potential consequences of the transaction both favorable and unfavorable.
- A complete copy of this Disclosure Statement has been provided to the Owner; and
- I have not made statements that differ from this material nor have I made any promises about the expected future values of this policy.

x _____
Signature of Insurance Agent

_____
Date: Month / Day / Year

_____
Insurance Agent PC Number, SSN, or TIN

► **NOTE:** • A copy of the Insurance Agent's Acknowledgment, page 7, must be sent in with application packet. (A complete copy of the product disclosure is to be left with the client).

• This Disclosure is intended to be used with Form SGUL18(NY).

Life Insurance Best Interest – Suitability Questionnaire

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

* S U I T *

This form gathers information to help an insurance agent and the Company determine whether a life insurance policy is suitable and in the proposed owner's best interest. We will protect and keep this information confidential.

1 Owner Information

- If the proposed owner is other than the insured, complete this form using the proposed owner's financial information.
- If a Trust will be the owner, complete this form using the Trust's financial information. You may include the financial information of the grantor, if living.

Any additional information that provides a more complete understanding of the suitability of a trust arrangement should be explained in the Recommendation Summary. All trust documentation must accompany this form.

Name of Proposed Owner	Date of Birth	Marital Status:
Last _____ First _____ M.I. ____		☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ N/A (Entity)
Number of Dependents, if applicable Age of Dependents		Work Status: ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Unemployed
Name of Entity, if Owner Date Established		Entity Type: ☐ Business ☐ Trust

1. The Company requires its producers to conduct a needs analysis to determine the proposed owner's insurance needs and financial objectives prior to making a recommendation. Did you perform a needs analysis?

☐ Yes ☐ No

2. Why is the proposed owner considering the purchase of a life insurance policy? (Check all that apply)

☐ Income Replacement (Family Needs) ☐ Debt Repayment (Mortgage, Personal Debt) ☐ Estate Planning/Conservation (Charitable Trust, Tax Planning)

☐ Final Expense ☐ Education ☐ Business Coverage

☐ Other (Please list) _____

3. In considering this product, what is the proposed owner's risk tolerance?

☐ Conservative (low risk) ☐ Moderate ☐ Aggressive (high risk)

4. Owner's Annual Income: $ _____

5. Has the proposed owner had experience with any of the following investments and insurance products? (Check all that apply)

☐ Stocks/Bonds ☐ Bank CDs/Savings ☐ Annuities
☐ Life Insurance ☐ Indexed Products ☐ Variable Products
☐ 401(k)/Pension Plans ☐ None ☐ Other (please list) _____

6. Does the proposed owner intend to use the proceeds of a reverse mortgage to pay for this product? ☐ Yes ☐ No

2 Replacements

The insurance agent must have reasonable grounds to believe that a replacement transaction is suitable, and the proposed owner would benefit from policy enhancements and improvements. Explain the benefits of a replacement policy compared to the existing policy in the Recommendation Summary.

7. Will the proposed life insurance policy replace another life insurance policy?

☐ Yes ☐ No **If Yes, answer all the questions within this section.**

8. Has the proposed owner replaced a life insurance policy within the last 36 months?

☐ Yes ☐ No If Yes, please explain in the Recommendation Summary.

Name of Company to be Replaced:

_____

Replaced Product Type:

☐ Term Life ☐ Indexed Life	☐ Whole Life	☐ Variable Life ☐ Universal Life

		Replaced	Proposed
a.	Is there a surrender charge? If yes, list the current dollar amount.	☐ No ☐ Yes $ _____	☐ No ☐ Yes
b.	If yes to a., what is the remaining Surrender Charge Period?	_____ Yrs.	_____ Yrs.
c.	Is the replaced/proposed policy qualified or non-qualified?	☐ Qualified ☐ Non-Qualified	☐ Qualified ☐ Non-Qualified
d.	Is there a Persistency Bonus? If yes, provide the amount or percentage and how long before bonus eligibility.	$ or % Yrs. ☐ No ☐ Yes _____ ____	
e.	Is there a Minimum Guaranteed Interest Rate over the life of the policy? (i.e. refer to the policy or contract) If yes, please list.	☐ No ☐ Yes ____ %	☐ No ☐ Yes ____ %
f.	Is the Death Benefit on the replaced policy greater than the proposed policy?	☐ Yes ☐ No	
g.	Does the replaced term product allow for conversion to a permanent policy? (If yes, provide an explanation in the Recommendation Summary why the conversion privilege was not exercised.)	☐ Yes ☐ No ☐ N/A	
h.	Does the replaced policy have a preferred rate class?	☐ Yes ☐ No	

i. Riders and Benefits

In the chart below, select all riders or benefits applicable for the replaced policy and the proposed policy, indicate if there is a cost and specify the duration of the benefit, if known. (Please use additional spaces and separate page if necessary.)

	Replaced		Proposed	
Type of Rider or Benefit	Cost Y/N	Duration	Cost Y/N	Duration
☐ Child Term				
☐ Spouse Term				
☐ Accelerated Death Benefit				
☐ Additional Purchase/Increase Guarantee				
☐ Return of Premium Rider or Cash Out Rider				
☐ Term Rider (Universal Life)				
☐ Waiver of Premium				
☐ Other (specify name and type)				

3 Recommendation Summary, Acknowledgement and Signatures

Insurance Agent

Did you provide the proposed owner the NAIC Buyer's Guide? ☐ Yes ☐ No

Recommendation Summary

American National expects its agents to gather appropriate suitability information to perform a needs analysis to determine that a transaction is suitable and in the best interest of the proposed owner. You must keep the documentation to support your recommendation and be prepared to provide it to the Company and or the New York Department of Financial Services—I acknowledge that I have obtained suitability information for the proposed owner as required by New York law including some or all of the following, as relevant to the proposed owner: age; annual income; financial situation and needs, including the financial resources used for funding of the policy; financial experience; financial objectives; intended use of the policy including riders; financial time horizon, including duration of existing liabilities and obligations; existing assets, including investment and insurance holdings; liquidity needs; liquid net worth; risk tolerance; willingness to accept non-guaranteed elements in the policy, including variability in premium, cash value, death benefit, or fees; tax status and any other information provided by the proposed owner which in my reasonable judgment is relevant to the suitability of the transaction. The compensation that I will receive for this sale did not influence my recommendation. I am recommending the product shown on the application for the following reasons:

- If this is a replacement, I am conditionally recommending this product, subject to my confirmation of favorable comparative data contained in the required replacement Regulation 60 Disclosure Statement.
- I believe it is suitable and in the best interest of the proposed owner based on:

  — The Product Disclosure Statement given to the proposed owner;

  — The following needs:

  ☐ Income Replacement ☐ Debt Repayment ☐ Estate Planning/Conservation
  ☐ Key Person ☐ Buy/Sell ☐ Loan Protection
  ☐ Supplement Retirement ☐ Tax Deferral ☐ Deferred Compensation
  ☐ Accelerated Death Benefit ☐ Additional Benefits/Riders ☐ Potential for source of cash (accumulation)
  ☐ Potential to earn interest related to a market index
  ☐ Other reasons why your recommendation is suitable and in the best interest of the proposed owner, including your replacement analysis, if applicable:

Agent's Recommendation Confirmation

Print Name

Signature of Insurance Agent

Date: Month/Day/Year

Additional Insurance Agent's Recommendation Confirmation (if commission split)

If commissions are being split all agents are subject to the requirements of NY Reg. 187. We require all agents to acknowledge that the transaction is suitable and in the best interest of the proposed owner. I acknowledge and agree that the recommendation is suitable and in the best interest of the proposed owner; and further I agree with the recommendation summary above.

Print Name

Signature of Additional Insurance Agent

Date: Month/Day/Year

Conditional Receipt

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

CRCT

Policy No. _____

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK. DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

I have received $ _____ in connection with an application for life insurance bearing the same serial number as this receipt. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

(1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
(2) A maximum of two medical examinations and tests required under the company's initial application, or reinstatement application, requirements must be completed and the reports of those medical examinations and tests must be received at the company's home office within 45 days after the date of this receipt;
(3) On the effective date, as defined below, all persons proposed for insurance must be insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
(4) There is no material misrepresentation in the application.

MAXIMUM AMOUNT LIMITATION: At no time and in no event shall the total liability of the company under this receipt and all other receipts providing conditional insurance coverage with the company on the lives of all the persons proposed for insurance exceed $500,000.

EFFECTIVE DATE MEANS THE LATEST OF: (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

REFUND OF PAYMENT: If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the company's liability is limited to a refund of the amount paid. Only the president, a vice president or secretary of the company has the authority to waive any of the company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

Date: Month/Day/Year | Signed at: City | State | Country

_____ | _____ | _____ | _____

Signature of licensed agent

X _____

I have read this conditional receipt. It has been explained to me by the agent.

Signature of primary proposed insured
(Or guardian, if proposed insured is under age 14½)

X _____

Signature of Owner

X _____

AMERICAN NATIONAL®

Application: Financial Statement Supplement

American National Life Insurance Company of New York
344 Route 9W, Glenmont, NY 12077

Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947 Business: (866) 490-3163
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408

* F S Q *

Name of Proposed Insured _____

The following financial disclosures are made for the purpose of establishing insurability for the amount of life insurance I have applied for on my life. They are furnished as a true and accurate statement of my current financial condition.

ASSETS		LIABILITIES	
Cash in banks	$	Notes payable to banks	$
Notes receivable	$	Notes payable to others	$
Accounts receivable	$	Accounts payable	$
Cash values life insurance	$	Loans on life insurance	$
Real estate	$	Taxes and interest due	$
Business interest (net of all liabilities)	$	Mortgages or liens on real estate	$
Stocks and bonds (not included above)	$	I.R.S. liens	$
Personal property (auto, furniture, etc.)	$	Contingent liabilities	$
Other assets (describe)	$	Other liabilities (describe)	$
Total Assets	**$**	**Total Liabilities**	**$**
		Total Net Worth (Assets-Liabilities)	**$**

INCOME	CURRENT CALENDAR YEAR	LAST CALENDAR YEAR	CALENDAR YEAR PRIOR
Gross annual salary	_____	_____	_____
Dividends, etc.	_____	_____	_____
Other income (describe)	_____	_____	_____
Total	_____	_____	_____

Are there any law suits pending or judgments against you at this time? ..... ☐ Yes ☐ No

If yes, please provide details? (Applicant may attach an additional sheet of paper, if necessary.) _____

_____

_____

Have you ever filed for bankruptcy? ..... ☐ Yes ☐ No

If yes, when? _____

Additional Remarks

_____

_____

_____

I hereby represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief, and I understand that they shall form a part of my application for insurance with American National Life Insurance Company of New York.

_____ _____

Signature of Proposed Insured Date

_____ _____

Witness Date

Addendum to Application - Additional Beneficiary Page for Life Insurance

American National Life Insurance Company of New York
344 Route 9W, Glenmont, NY 12077

Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947 Business: (866) 490-3163
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408

* B E N E A P P *

Provide corresponding application / policy number: _____ / Select the appropriate box for which this page applies.

❑ **Primary Proposed Insured** ❑ **Additional Proposed Insured** ❑ **Other Insured Rider** _____

1. PROPOSED INSURED

a. Last name | First name | M.I. | b. Social Security/Tax ID number | c. Telephone Number

d. Date of birth: Month/Day/Year | e. Residence address: Number/Street | f. City | g. State | h. ZIP

2. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name | First name | M.I. | b. Social Security/Tax ID number | c. Telephone Number

d. Date of birth: Month/Day/Year | e. Residence address: Number/Street | f. City | g. State | h. ZIP

3. ADDITIONAL BENEFICIARY INFORMATION *(Unless specified, all beneficiaries in the same class share equally.)*

Primary: Last name | First name | M.I. | Relationship to proposed insured | Date of Birth: Mo./Day/Yr. | Gender: M/F | Soc. Sec./Tax ID# | Date of trust: Mo./Day/Yr. | % payable

Is any Beneficiary NOT living at the same address as the Proposed Insured? ☐ Yes *(If "Yes," complete question a.)* ☐ No

a. Telephone Number | Mailing address: Number/Street | City | State | ZIP

Contingent: Last name | First name | M.I. | Relationship to proposed insured | Date of Birth: Mo./Day/Yr. | Gender | Soc. Sec./Tax ID# | Date of trust: Mo./Day/Yr. | % payable

Is any Beneficiary NOT living at the same address as the Proposed Insured? ☐ Yes *(If "Yes," complete question b.)* ☐ No

b. Telephone Number | Mailing address: Number/Street | City | State | ZIP

4. USE FOR ADDITIONAL BENEFICIARY DESIGNATIONS OR FOR SPECIAL BENEFICIARY SETTLEMENT OPTIONS:

(The name, address, telephone number, date of birth, and SSN is required for any additionally named beneficiary(ies).)

I hereby represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief, and I understand that they shall form a part of my application for insurance with American National Life Insurance Company of New York.

Date: Month/Day/Year

Signature of primary proposed insured
(Or guardian, if proposed insured is under age 14 1/2)
X _____

Witnessed by: Signature of licensed agent (If applicable)
X _____

Signature of additional person(s) proposed for insurance
X _____

Print agent's name

Signature of additional person(s) proposed for insurance
X _____

Agent's state license number / company personal code

Signature of owner if other than proposed insured
X _____

Trust Certification

American National Life Insurance Company of New York

Mailing Address Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Phone 1-866-490-3163

* T R U S T *

▶ **NOTE:** This form is to be completed when a trust is named as owner or beneficiary.

1 Contract Policy Information

Proposed Insured's First Name M.I. Last Name

Trust will be: ☐ Owner ☐ Beneficiary ☐ Both Owner and Beneficiary

2 Information about the Trust

In consideration of American National Life Insurance Company of New York opening and/or maintaining one or more contracts and/or policies with the Trust named below as owner or beneficiary, the undersigned Trustee(s), certify as follows:

Full Name of the Trust

Date Trust Created | State Where Trust Created | Date of Latest Trust Amendment

Trust Tax Identification Number | Name of Grantor/Settlor Who Established Trust

Street Address | City | State | ZIP

Type of Trust: ☐ Revocable ☐ Irrevocable ☐ Testamentary

If Multiple Trustees: ☐ a majority may act for all ☐ anyone may act independently ☐ all must act unanimously

Name of the Successor Trustee(s) (if any)

x **Signature of Successor Trustee(s)** (if any)

What is the length and nature of relationship between the Trustee(s) and Grantor/Settlor:

Does the Trust contain a spendthrift Provision that prohibits a beneficiary or creditor of a trust beneficiary from anticipating or attaching an interest in the trust? ☐ **Yes** ☐ **No***

***If No**, explain reason for leaving this provision out:

Can the trust be merged or consolidated with another trust? ☐ **Yes** ☐ **No**

Is the beneficiary granted a power of appointment (ability to appoint property during life or at death)? ☐ **Yes*** ☐ **No**

***If Yes**, is the power limited to persons who (a) are related to the insured by blood or law, (b) have a substantial interest in the proposed insured engendered by love and affection, or (c) hold a lawful and substantial economic interest in the continued life of the proposed insured? ☐ **Yes** ☐ **No**

3 Declarations and Certifications

The undersigned Trustee(s) do hereby declare, certify and understand the following:

1. All information provided on this Certification is accurate and complete.
2. The named trust is currently in effect and has not been revoked, modified or amended in any manner that would cause the representations in this Certification to be incorrect.
3. Beneficial interest under the Trust can and will only be established for persons who (a) are related to the Proposed Insured by blood or law, (b) have a substantial interest in the Proposed Insured engendered by love and affection, or (c) hold a lawful and substantial economic interest in the continued life of the Proposed Insured.
4. That American National Life Insurance Company of New York ("the Company") is relying exclusively on the representations in this Certification and not upon a review of the trust document, even if the trust document has been or is later provided. The Company reserves the right to require the trustee(s) to provide a copy of the trust agreement either before or after the Policy is issued, for any reason the Company may determine. The Company is permitted to rely upon the representations in this Certification, unless or until notice of any change, amendment, or revocation is provided in writing and delivered to the Company.
5. I/We are duly authorized to act as trustee(s) under the terms of the trust provisions and/or applicable law. I/We have the power to exercise all rights associated with ownership of a life insurance policy, including, but not limited to, purchase, surrender, selection of and transfers between variable funding options, withdrawal of funds, taking a loan or other encumberment and assignment of the policy.
6. Each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company and agrees to hold the Company harmless against all obligations, demands, losses or liabilities (including attorney's fees) that the Company incurred, suffered, or paid or may incur, suffer or pay in the future because of the Company's reliance on this Certification and/or transactions or actions by the undersigned. By indemnifying the Company, each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company's agents, officers and employees. This indemnification shall survive termination of this document or the life insurance policy.
7. That neither the Company nor its agents are responsible for estate planning and tax implications associated with the Trust's ownership of a life insurance policy, that they may not give legal or tax advice and that the Company's acceptance of this Certification is not an endorsement of the named trust. I/We have had the opportunity to consult with an independent attorney and/or tax advisor, to the extent necessary, before executing this Certification.
8. **I/We agree to inform the Company immediately in writing of any trust amendments, change of trustee(s), or other facts and events that would affect or alter the recipients of the beneficial interest of the Trust or any of the representations in this Certification.**
9. The Proposed insured has been informed or is otherwise aware that a policy is being purchased on his/her life.
10. That the Company will not be responsible for the performance of said trustee's duties as trustee, nor for the use of any money paid to such trustee and will be fully discharged in making any payment to such trustee and it is agreed that no trust referred to herein shall vary the terms of the insurance contract or application or be otherwise binding on the Company.

Name of Trustee #1 (please print) | x **Signature of Trustee #1** | **Date:** Month/Day/Year

Street Address | City | State | ZIP

Name of Trustee #2 (please print) | x **Signature of Trustee #2** | **Date:** Month/Day/Year

Street Address | City | State | ZIP

Name of Trustee #3 (please print) | x **Signature of Trustee #3** | **Date:** Month/Day/Year

Street Address | City | State | ZIP

AMERICAN NATIONAL

Non-Qualified Transfer and 1035 Exchange Request

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Mailing Address:
Mail Processing Center, P.O. Box 4408, Springfield, MO 65808-4408
Business: (866) 490-3163

Complete this form for Non-Qualified Accounts Only

1. Funds Coming From

CHECK ONE:

☐ **New Sale** ☐ **Existing Policy/Contract/Account Number:** _____

Transfer Company Policy/Contract/Account Information:

Transfer Company Name: _____ **Transfer Company Phone Number:** _____ **Transfer Company Fax Number:** _____

Transfer Company Address: Number/Street _____ **City** _____ **State** _____ **Zip** _____

Name of Insured/Annuitant*: _____ **Social Security Number:** _____

Name of Owner: _____ **Social Security Number:** _____

Name of Joint Owner: _____ **Social Security Number:** _____

Policy/Contract/Account Number with Transfer Company: _____

***Joint Annuitants are Only Accepted on Immediate Annuities**

2. Authorization for 1035 Exchange, Non-Qualified Policy/Contract/Account Only

I/We direct the Institution named above to liquidate and transfer the assets to American National Life Insurance Company of New York in order to set up a Non-Qualified account: (*Must Specify*)

☐ Immediately ☐ Upon Maturity: ____/____/_____

☐ **Full 1035 Exchange** $ _____

The Assignor hereby designates American National Life Insurance Company of New York as beneficiary of the above policy/contract/account.

Immediately following the above beneficiary designation, Assignor does hereby assign and transfer without exceptions, limitations or reservation to American National Life Insurance Company of New York all assignable benefits, interest, property, rights, claims, options, privileges, obligations and title in the policy/contract in exchange for a new policy/contract as described in Assignor's application to American National Life Insurance Company of New York for such policy/contract.

Assignor and American National Life Insurance Company of New York expressly represent and recognize that the sole purpose of this assignment is to affect an exchange of insurance policies/contracts. Assignor represents and agrees that Assignor has consulted his/her own tax advisor regarding the tax consequences of this transaction. Assignor represents and agrees that American National Life Insurance Company of New York has made no representations concerning Assignor's tax treatment under Internal Revenue Code Section 1035 or otherwise as a result of this transaction. American National Life Insurance Company of New York assumes no responsibility or liability for the assignor's tax treatment under Internal Revenue Code Section 1035(a) or otherwise as a result of this transaction.

☐ Partial 1035 Exchange ☐ $ _____ ☐ _____ %

I understand the Internal Revenue Service may take the position that an exchange of a portion of an existing life insurance policy/annuity contract for a new life insurance policy or an annuity contract, or the exchange of a portion of an existing life insurance or annuity contract for a new life insurance policy or annuity contract, does not qualify as a valid exchange under Section 1035 of the Internal Revenue Code. I understand, acknowledge, and agree that American National Life Insurance Company of New York assumes no liability or responsibility for any tax consequences associated with the proposed partial exchange.

Please complete the information below if 1035 Exchange includes loan value:

$ _____ **Amount of 1035 Exchange** **$** _____ **Amount of loan included in 1035 Exchange (Not available with all products)**

Appropriate loan form must be submitted with the application if transferring loan value.

AMERICAN NATIONAL

3. Non-Qualified Transfer of Funds (Non-1035 Exchange)

I/We direct the Institution named above to liquidate and transfer the assets to American National Life Insurance Company of New York in order to set up a Non-Qualified policy/contract: (*Must Specify*)

☐ Immediately ☐ Upon Maturity: _____/_____/_____

☐ **Mutual Funds Shares** ☐ **Certificate of Deposit**

☐ **Brokerage Account** ☐ **Money Market**

☐ **Other** _____

I wish to liquidate and transfer:

☐ **Entire Value** ☐ **Partial Value, in the amount of $ _____ or _____% of the above referenced policy/contract/account directly to the receiving company**

4. Policy/Contract/Account Statement

☐ Policy/Contract/Account Included (*If contract is not lost, please submit with this form.)*

☐ Certificate of Lost Policy/Contract/Account

I/We certify that the above numbered policy/contract/account has been lost or destroyed and to the best of my/our knowledge and belief, is not in anyone's possession.

5. Special Instructions

_____

_____

_____

_____

6. Signatures

I/We agree that (1) American National Life Insurance Company of New York is participating in this transaction at my specific request and as an accommodation to me: (2) American National Life Insurance Company of New York and its representatives make no representation concerning treatment under IRC Section 1035(a) or otherwise; (3) American National Life Insurance Company of New York assumes no responsibility nor any liability for the validity of this transaction or for the tax treatment under IRC Section 1035(a) and assumes that I/We consulted a tax advisor; (4) No person, firm, or corporation has a legal or equitable interest under the above referenced policy/contract/account, except the undersigned, and no proceedings of either a legal or equitable nature have been instituted or are pending against the undersigned or involving the above referenced policy/contract/account; and (5) the full-partial distribution from my existing policy/contract/account may be subject to surrender charges.

I/We authorize the transaction described above.

For the benefit of: _____

Date at _____ this _____ day of _____ , _____

(City, State)

x _____
Signature of Insured/Annuitant

x _____
Signature of Joint Annuitant (for Immediate Annuities)

x _____
Signature of Owner (if other than Annuitant)

x _____
Signature of Joint Owner (if other than Annuitant)

x _____
Signature of Guarantee (if Required)

x _____
Signature of Agent

x _____
Signature of Witness

x _____
Signature of Witness

AMERICAN NATIONAL

7. Acceptance (*To be completed by American National Life Insurance Company of New York)*

The authorized signature below certifies acceptance of the assignment and surrender or transfer of funds as instructed in this request. After deducting any sums as are permitted under the plan, please complete this transaction and send a check with a copy of this form to:

☒ **New York Unit**

American National Life Insurance Company of New York
P.O. Box 4408
Springfield, MO 65808-4408
Phone Number: 1-866-490-3163

If shipping via overnight service:

American National Life Insurance Company of New York
Mail Processing Center
Attn: New York Unit 4408
1949 E. Sunshine St.
Springfield, MO 65899-0001

Please make check payable to: American National Life Insurance Company of New York

By _____ Date _____

(Signature/Title)

For all 1035 Exchanges, please provide the Cost Basis Information for the current policy/contract/account.

ACH Debit Authorization / Standing Authorization for Life Policies

American National / One Moody Plaza, Galveston, TX 77550-7947

Overnight Address

Career Sales and Service Division: Mailing Processing Center, Attn: CSSD, LPA 4448, 1949 E. Sunshine St. Springfield, MO 65899-0001 / **Phone** 1-800-899-6806

Life Insurance Services: Mailing Processing Center, Attn: LIS 3257, 1949 E. Sunshine St. Springfield, MO 65899-0001 / **Phone** 1-800-899-6806

* P A C *

Mailing Address

Career Sales and Service Division: Mailing Processing Center, P.O. Box 4448, Springfield, MO 65808-4448

Life Insurance Services: Mailing Processing Center, P.O. Box 3257, Springfield, MO 65808-3257

1 Company Selection

- ☐ American National Insurance Company
- ☐ American National Life Insurance Company of Texas
- ☐ Garden State Life Insurance Company
- ☐ American National Life Insurance Company of New York
- ☐ Standard Life and Accident Insurance Company

2 Policy Information

Policy Number	Policy Owner	Insured
Policy Number	Policy Owner	Insured
Policy Number	Policy Owner	Insured
Policy Number	Policy Owner	Insured

Agent Name (optional)

_____

3 Recurring Payments

☐ Life and Whole Life

Withdrawal Amount:
(Please refer to the schedule of premiums in the data section of your policy. The withdrawal amount may change as outlined in your contract, or with contract changes.)

Withdrawal Date: _____

Withdrawal Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Universal Life and Indexed Universal Life

Withdrawal Amount: _____

Withdrawal Date: _____

Withdrawal Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Loan Payments (if policy or contract has an outstanding loan, and the premium is on automatic withdrawal)

Withdrawal Amount: _____

(The minimum loan payment amount is $15 unless your contract specifies a different amount.)

Withdrawal Date:

☐ I acknowledge the loan payment withdrawal date will be the same as the premium withdrawal date.

Withdrawal Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Multiple Policies Debited as a Single Withdrawal Amount

The single withdrawal billing option is available for policies issued by the same Company. It is not available for variable life policies or annuities.

4 One-Time Payment

Withdrawal Amount
$_____

Withdrawal Date
_____

5 Standing Authorization

I may request that the Company initiate a one-time payment using the bank account information below by contacting the Company at the phone numbers listed above.

6 Authorization

I hereby authorize the selected company and its affiliates (the "Company") to electronically debit my account (and if necessary to electronically credit or debit my account to correct erroneous transactions) in accordance with the selections above to pay premiums and other charges for the listed insurance policies and annuity contracts. I agree that ACH transactions I authorize must comply with applicable law, and I agree to comply with National Automated Clearing House (Nacha) rules and regulations about electronic transfers. I also agree to maintain an adequate balance in my account to cover my insurance premiums and other charges. The Company will not be liable for any bank service fees charged against the account.

If no withdrawal date is specified, the withdrawal date will be the day of the issue date of the contract. If the withdrawal date falls on a weekend, holiday, or date that does not exist, the withdrawal will occur on the next banking day. The Company will give written notice to the policy owner, and if different, the bank account owner of any increase in the withdrawal amount 10 days in advance or as otherwise required by law. I do not require advance notice of any decrease in the withdrawal amount. If the withdrawal amount decreases, the new amount will be withdrawn at the next scheduled date, and the Company will notify the policy owner, and if different, the bank account owner, in writing of the decrease.

Except as specified in Section 7 below, I understand that this authorization will remain in full force and effect until I revoke the authorization in writing to the mailing address at the top of this form. The Company requires at least 10 days advance written notice to process revocation. The Company reserves the right to cancel this authorization at any time. The Company may amend this authorization at any time by giving 30 days advance written notice.

7 Return for Insufficient Funds or Invalid Bank Account

I understand and agree that:

1. All debits are accepted by the Company subject to their being honored upon presentation.
2. If the funds in my account are insufficient to pay a debit:
- **a.** The Company will notify the policy owner, and if different, the bank account owner.
- **b.** The Company reserves the right, at the next available opportunity, to resubmit the withdrawal amount for presentation against the designated bank account; however, the Company is not required to do so.
- **c.** For term life, whole life, and health, the Company will suspend the pre-authorized payment privilege until the premium is paid current.
- **d.** For universal life, variable life, and annuities, the Company will discontinue the pre-authorized payment privilege until it receives a new authorization.

3. If the account is invalid, the Company will discontinue the pre-authorized payment privilege until it receives a new authorization.
4. If a payment is not made when due, the payment status and duration of the policy or contract will be governed by the contract terms for insufficient payment.

8 Bank Account Information

☐ Checking ☐ Savings

Bank or Depository Institution

Branch

Account Number
#

Routing Number
#

City

State

ZIP

9 Bank Account Owner Information

First Name

M.I.

Last Name or Non-Natural Entity Name

Mailing Address

City

State

ZIP

Telephone

Bank Account Owner Relationship to Policy Owner

Email Address

10 State Specific Fraud Language

For California Residents:

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

11 Signature

x

Signature of Bank Account Owner

Date: Month / Day / Year

ATTACH YOUR VOIDED CHECK (OPTIONAL)

This is encouraged to ensure the accuracy of your banking information.

Life Insurance Buyer's Guide

American National Life Insurance Company of New York
344 Route 9W, Glenmont, NY 12077

Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947 Business: (866) 490-3163
Mail Processing Center, Life Insurance Administration, 1949 E. Sunshine St., Springfield, MO 65899-0001

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by American National Life Insurance Company of New York

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.

- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able trade many term insurance policies for a cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and study it carefully. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies—those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.