AMERICAN NATIONAL®

Application For Reinstatement of Individual Life Insurance

American National Life Insurance Company of New York

Policy No. _____

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

* R E I N *

1. PRIMARY PROPOSED INSURED

a. Last name | First name | M.I. | Occupation/Job Title

b. Date of birth: Month/Day/Year | c. Age last birthday | d. Height | e. Weight | f. Social Security Number | Annual Income | Net Worth

g. Residence address: Number/Street | City | State | ZIP | h. Personal Telephone (_____) _____

2. ADDITIONAL PROPOSED INSURED

a. Last name | First name | M.I. | Occupation/Job Title

b. Date of birth: Month/Day/Year | c. Age last birthday | d. Height | e. Weight | f. Social Security Number | Annual Income | Net Worth

g. Residence address: Number/Street | City | State | ZIP | h. Personal Telephone (_____) _____

3. MEDICAL HISTORY QUESTIONS—LIFETIME

(For questions "3.a." through "5.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 6. Attach an additional sheet of paper, if necessary.)

a. Is any Proposed Insured taking any medication(s)? ☐ Yes ☐ No *(If "Yes," list medications and prescribed dosages).*

HAS ANY PROPOSED INSURED EVER BEEN DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION ...

b. for a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia, or any disease or abnormality of the heart, blood or blood vessels (excluding a positive HIV test)? ☐ Yes ☐ No

c. for cancer, a tumor or abnormal growth of any kind? ☐ Yes ☐ No

d. with an Immune Deficiency Disorder, AIDS, or AIDS Related Conditions (ARC)? ☐ Yes ☐ No

4. MEDICAL HISTORY QUESTIONS—LAST TEN YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS, BEEN DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION FOR …

a. seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness, or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No

b. asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD), or any disease or abnormality of the respiratory system? ☐ Yes ☐ No

c. any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis, and colitis? ☐ Yes ☐ No

d. any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? ☐ Yes ☐ No

e. diabetes or any disease of the thyroid or other gland? ☐ Yes ☐ No

f. arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears, or skin? ☐ Yes ☐ No

g. treatment or counseling for use of alcohol or alcoholism? ☐ Yes ☐ No

h. treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics, or other habit-forming drugs, other than those prescribed by a physician? ☐ Yes ☐ No

i. Does any Proposed Insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed? ☐ Yes ☐ No

j. If any Proposed Insured(s) is less than one year old, give birth weight: | ____ lb. | ____ oz. Was birth premature? ☐ Yes ☐ No

AMERICAN NATIONAL

5. MEDICAL HISTORY QUESTIONS—LAST FIVE YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS, CONSULTED OR BEEN TREATED BY A MEMBER OF THE MEDICAL PROFESSION …

a. for any cause not previously mentioned in this application? ..... ☐ Yes ☐ No
b. for a treadmill EKG or other cardiovascular test, chest X-ray, blood, or other laboratory test? ..... ☐ Yes ☐ No
c. for a surgical operation or been under observation or treatment in any hospital or clinic or been advised by a member of the medical profession to have an operation which was not performed? ..... ☐ Yes ☐ No

6. MEDICAL HISTORY EXPLANATIONS

(Give full details below of all "Yes" answers to questions "3.a." through "5.c." Attach an additional sheet of paper, if necessary.*)*

Question | Person | Reason, condition, disease, injury, etc. | Date

_____ | _____ | _____ | _____

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

_____ | _____ | _____ | _____ | _____

Question | Person | Reason, condition, disease, injury, etc. | Date

_____ | _____ | _____ | _____

% of recovery | Name of attending physician | Attending physician address: Number/Street | City | State

_____ | _____ | _____ | _____ | _____

Add a separate sheet of paper signed, dated, and witnessed for additional medical history explanations.

7. NON-MEDICAL HISTORY

a. Has any Proposed Insured had a conviction of DWI/DUI or reckless driving in the last five (5) years? ..... ☐ Yes ☐ No
(If "Yes," give details. Applicant may attach additional sheet of paper to provide details, if necessary.) | _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I have received and read the MIB, Inc. Pre-notification and Fair Credit Reporting Act Pre-notifications. I authorize American National Life Insurance Company of New York to request such a report, and authorize the preparation of such report.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to American National Life Insurance Company of New York, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on American National Life Insurance Company of New York or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, including for Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) for underwriting purposes, hospitalizations or confinements, ailments, and/or tobacco usage of the applicant(s). It is understood that American National Life Insurance Company of New York underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:
(1) such information will be used by American National Life Insurance Company of New York for underwriting and insurability determinations;
(2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
(3) a picture copy or photocopy of this authorization shall be as valid as the original; and
(4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization except to the extent that American National Life Insurance Company of New York has taken action in reliance on it, by sending written notice to the Life Underwriting Department of American National Life Insurance Company of New York, Administrative Office: P.O. Box 1890, Galveston, Texas 77553-1890, Mail Processing Center, P.O. Box 4408, Springfield, Missouri 65808-4408. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

AMERICAN NATIONAL

REINSTATEMENT DECLARATIONS AND AGREEMENTS

Each of the undersigned declares for themselves that all of the answers in all pages of this application for reinstatement and any supplements to it are full, complete and true to the best of their knowledge and belief. Each of the undersigned agrees that: (1) the statements and answers above refer to the person named in the policy as the Insured, and to all persons insured or to be insured thereunder; (2) this application and all statements and answers contained herein shall be considered a supplement to the original application, shall form the basis for reinstatement and shall become a part of the policy of insurance for which application for reinstatement is made; (3) all statements and answers made in the original application for this policy are hereby ratified and confirmed except such as are modified by statements or answers herein contained; (4) the reinstatement of this policy shall not be effective until (a) approved at American National Life Insurance Company of New York's Administrative Office and (b) all premiums in default and additional payments required for reinstatement of this policy are received at American National Life Insurance Company of New York's Administrative Office during the lifetime of all persons insured or to be insured under this policy; (5) if the policy is not reinstated by American National Life Insurance Company of New York, its only liability in connection with this application for reinstatement shall be for the refund of all sums tendered herewith; (6) information disclosed to or knowledge on the part of any medical examiner or representative of American National Life Insurance Company of New York as to any facts pertaining to any person insured or to be insured under this policy shall not be considered as knowledge of American National Life Insurance Company of New York unless reduced to writing and made a part of this application.

APPLICATION SIGNATURES

If Provisional Receipt to be detached, I hereby certify that I have read and received the Provisional Receipt, and agree to its terms. I understand that American National Life Insurance Company of New York will not permit acceptance of my deposit or detachment of the Provisional Receipt unless this statement is true (if one given).

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.

I have on _____ made payment of $ _____ to _____ as a consideration for reinstatement for which I hold Provisional Receipt.

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

_____ | _____ | _____ | _____

Witnessed by: Signature of witness or licensed agent

X _____

Print agent's name

_____

Agent's state license number / company personal code

_____

Signature of Primary Proposed Insured
(Or guardian, if Proposed Insured is under age 14½)

X _____

Signature of additional person(s) proposed for insurance

X _____

Signature of Owner if other than Proposed Insured

X _____

AMERICAN NATIONAL

* C R C T *

Policy No. _____

PROVISIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK
Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947
Mail Processing Center, Life Insurance Administration, 1949 E Sunshine St, Springfield, MO 65899-0001

PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK.

RECEIVED FROM _____ the sum of _____ ($ _____) on account of application for reinstatement of said policy, which lapsed for non-payment of premium. Said sum is to be held for the applicant's account without obligation on the part of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK until said application for reinstatement is (a) approved at the Company's Administrative Office and (b) all premiums in default, and any additional payment required for reinstatement of this policy are received at the Company's Administrative Office during the lifetime of all persons insured or to be insured under this policy. If the policy is not reinstated by the Company, its only liability in connection with this application for reinstatement shall be for the refund of all sums tendered herewith. No medical examiner or representative of the Company except the President, a Vice-President, or the Secretary has the authority to waive the answer to any question in any application or application for reinstatement of insurance, to modify any such application, or to bind the Company by making any promise or representation.

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

Signature of licensed agent

X _____

I have read this Provisional Receipt. It has been explained to me by the agent.

Signature of Proposed Insured
(Or guardian, if Proposed Insured is under age 14½)

X _____

Signature of Owner

X _____

AMERICAN NATIONAL

* M I B *

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

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK
Administrative Address:
One Moody Plaza, Galveston, TX 77550-7947
Mail Processing Center, Life Insurance Administration, 1949 E Sunshine St, Springfield, MO 65899-0001

Thank you for considering American National Life Insurance Company of New York as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

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) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is: 50 Braintree, Suite 400, Braintree, MA 02184-8734.

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

Fair Credit Reporting Act Pre-notification — Federal and state laws require notification that, in connection with your application, we may request an investigative consumer report. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or, for the appropriate fee, receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, if any, living conditions and type of community.