American National Life Insurance Company of Texas
Administrative Office: P.O. Box 1870, Galveston, TX 77553-1870
800.899.6520

ENROLLMENT APPLICATION FOR MEDICARE SUPPLEMENT (Please Print — Black Ink)

SECTION A

1. Applicant ______________________________ Date of Birth ______________ Age _______
   Home Address ______________________________ City ______________ State ______ Zip __________
   Phone (_____) ______________________________ Email ______________________________
2. Billing Address (if different) ______________________________ City ______________ State ______ Zip __________
3. Height _________ Weight _________

SECTION B

4. **I, AS A MEMBER OF THE NCAA, APPLY FOR:**
   Plan ___________ ❑ Male ❑ Female ❑ Non Tobacco User ❑ Tobacco User
5. **Payment Mode:** ❑ Annual ❑ Semiannual ❑ Quarterly ❑ Monthly Bank Draft
6. **Requested Effective Date:** _______________

SECTION C

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your enrollment application.

PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X".

To the best of your knowledge:

7. Did you turn age 65 in the last 6 months?
   ❑ **Yes** ❑ **No**
8. Did you enroll in Medicare Part B in the last 6 months?
   ❑ **Yes** ❑ **No**
9. If Yes, what is the effective Date? _________________
   If Yes, give Medicare claim number from your Medicare Card ______________________________
10. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost”, please answer NO to this question.)
    ❑ **Yes** ❑ **No**
    If Yes, will Medicaid pay your premiums for this Medicare Supplement policy?
    ❑ **Yes** ❑ **No**
    If Yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
    ❑ **Yes** ❑ **No**
11. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave “END” blank.
    START ____/____/____ END ____/____/____
    If you are still covered under a Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement Certificate?
    ❑ **Yes** ❑ **No**
    Was this your first time in this type of Medicare plan?
    ❑ **Yes** ❑ **No**
    Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
    ❑ **Yes** ❑ **No**
12. Do you have another Medicare Supplement policy in force?
    ❑ **Yes** ❑ **No**
    If so, with what company, and what plan do you have?
    ____
    If so, do you intend to replace your current Medicare Supplement policy with this Certificate?
    ❑ **Yes** ❑ **No**

SECTION C *(continued)*

13. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)

    ❑ **Yes** ❑ **No**

    If so, with what company and what kind of policy?

    ____

    What are your dates of coverage under the other policy?

    START ____/____/____ END ____/____/____

    (If you are still covered under the other policy, leave "END" blank.)

14. Do you qualify for open enrollment?

    ❑ **Yes** ❑ **No**

    If Yes, please explain.

    ____

15. Do you qualify for guarantee issue?

    ❑ **Yes** ❑ **No**

    If Yes, please submit proof with enrollment application.

SECTION D

COMPLETE IF APPLYING FOR A MEDICARE SUPPLEMENT ON A NON-OPEN ENROLLMENT OR NON-GUARANTEE ISSUE BASIS.

If the answer to any question in Section D (16-19h) is "Yes", the enrollment application should not be submitted.

16. Are you now bedridden, confined to a nursing home, assisted living facility, hospital or receiving the services of a home health care agency?

    ❑ **Yes** ❑ **No**

17. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?

    ❑ **Yes** ❑ **No**

18. Within the last **2 years**, have you:

    a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given?

       ❑ **Yes** ❑ **No**

    b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip?

       ❑ **Yes** ❑ **No**

    c) required the use of a wheelchair, walker or cane?

       ❑ **Yes** ❑ **No**

    d) been advised to have cataract surgery or other eye surgery that has not been performed?

       ❑ **Yes** ❑ **No**

19. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:

    a) Cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission?

       ❑ **Yes** ❑ **No**

    b) Congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement?

       ❑ **Yes** ❑ **No**

    c) Uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?

       ❑ **Yes** ❑ **No**

    d) Emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?

       ❑ **Yes** ❑ **No**

    e) Ulcerative colitis, Crohn's disease, cirrhosis of liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?

       ❑ **Yes** ❑ **No**

    f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?

       ❑ **Yes** ❑ **No**

    g) Mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?

       ❑ **Yes** ❑ **No**

    h) Incontinence, any ostomy present due to disease, an organ transplant other than corneal?

       ❑ **Yes** ❑ **No**

20. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?

    ❑ **Yes** ❑ **No**

    If "Yes", give information regarding diagnosis or condition.

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SECTION E

NOTICE TO MEDICARE SUPPLEMENT APPLICANT

The Applicant must read the following statements or the Agent must read the following statements to the Applicant.

You do not need more than one Medicare supplement policy. If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

You may be eligible for benefits under Medicaid and may not need Medicare Supplement coverage.

If, after purchasing this coverage, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement coverage can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement coverage (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION F

AGREEMENT — I have read or had read to me my completed enrollment application (including the statements in Section E). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my certificate. I realize any false statement or misrepresentation in my enrollment application may result in loss of coverage under my certificate.

FRAUD WARNING — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MEDICARE SUPPLEMENT ACKNOWLEDGMENT — I have received the outline of coverage and *Guide to Health Insurance for People with Medicare* from the Agent.

Applicant's Signature ______________________________ Date ______________

City ______________________ State ______________ Zip ______________

A TELEPHONE INTERVIEW WILL BE CONDUCTED.
What will be the best time to contact the Applicant for the telephone interview?

____

____

AGENT'S STATEMENT

I certify that: 1) I saw the Applicant; 2) I asked the Applicant the questions in the enrollment application and truly and accurately recorded the answers; 3) the answers did not conflict with my observations and knowledge of the Applicant; 4) I witnessed the Applicant's signature; and 5) I gave the Outline of Coverage and *Guide to Health Insurance for People with Medicare* to the Applicant and, if applicable, a copy of appropriate form(s) and/or disclosure(s).

I also certify that: 1) the Applicant has read, or had read to him or her, the completed enrollment application (including the statements in Section E); and 2) the Applicant realizes that any false statement or misrepresentation in the enrollment application may result in loss of coverage under the certificate.

I certify that I have verified the Applicant's identity by viewing a U.S. federal or state government-issued I.D.:
❏ Driver's License ❏ Passport ❏ Government-issued Identification Card ❏ Other

The Company names, policy numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"): ____________________

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The Company names, policy numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"):____________________

____

AGENT INFORMATION

Name (printed)____________________ Signature ____________________

Agent Code ____________________ Date Signed ____________________

Email ____________________ Fax ____________________ Phone ____________________

Premium Quoted $ __________ Premium Collected $ __________
(including the $20 application fee)

Receipt Given: ❏ Yes ❏ No

❏ No money collected. Initial premium is to be drafted.

Mail Certificate to: ❏ Insured ❏ Agent

Special Requests:____________________

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AUTHORIZATION TO MY BANK

MONTHLY BANK DRAFT AUTHORIZATION

Attach Voided Check Or Deposit Ticket Here And Sign Authorization

❏ **Checking**

❏ **Savings**

Bank Information

____
Name

____________________ ____________________ ____________________
City State Zip

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of American National Life Insurance Company of Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

____________________ ✓ ____________________
Date Signed Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number ____________________

Routing Number ____________________

RECEIPT

CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY ENROLLMENT APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS. If coverage is not issued, the initial premium will be refunded to the Applicant. If a Certificate is issued, coverage will begin on the date of issue shown in the certificate.

Received from ____ on ___________________________________
Date

an enrollment application for Plan(s) ____________ and a ❑ Check ❑ Money Order

for $ ______________________________________
(including the $20 application fee)

Applicant's Signature ____

DISCLOSURE NOTICE

In connection with your enrollment application, American National Life Insurance Company of Texas (ANTEX), or it's reinsurers, may obtain medical and other information for evaluation purposes. ANTEX may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically-related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given to you. That information could concern drugs, alcoholism or mental illness. ANTEX may also obtain an investigative consumer report on you.

Information regarding your insurability will be treated as confidential. ANTEX or its reinsurers may, however, make a brief report thereon to MIB, 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 a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

ANTEX, or its reinsurers, may also release information in 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.

If an investigative consumer report is prepared in connection with your enrollment application, you may request to be interviewed for that report. Also, you have the right to review and note any corrections concerning reported personal information in ANTEX's file, unless the information is privileged.

This notice is only a summary. You may request additional information about ANTEX's information collection practices and your rights by contacting ANTEX.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS • P.O. Box 1870, Galveston, Texas 77553-1870 • 800.899.6520

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician; medical practitioner; Hospital; clinic or other medical related facility; insurance company; insurance support organization; business partner, pharmacy, government agency; group policyholder; employer; benefit plan administrator; the Medical Information Bureau; the Department of Motor Vehicle Registration; and paramedical facility, to provide American National Life Insurance Company of Texas 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 Texas or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that American National Life Insurance Company of Texas underwriters, 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 Texas for underwriting and insurability determinations;
2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3) a picture copy or photocopy of this authorization shall be as valid as the original; and
4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of American National Life Insurance Company of Texas, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

______________________________	______________________________
Date	Applicant's Signature
______________________________	______________________________
Witness	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other______________________________

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