AMERICAN NATIONAL®

Application for Policy Change to Individual Life Insurance

American National Life Insurance Company of New York

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

INSTRUCTIONS:

1. Print in black ink. Do not use ditto marks.
2. Submit ENTIRE policy for all changes.
3. Read instructions on page before completing form.
4. You may call the number above for any questions regarding the completion of this form.

I/We hereby request that Policy No. _____ on the life of _____ be changed as indicated below.

Date of Birth _____ Height _____ Weight _____ S.S. # _____ / _____
Mo/Day/Yr Ft/In Lbs Insured Other Proposed Insured

❑ 1. TERM CONVERSION

IMPORTANT: If the amount of insurance on the new plan is greater than that of the present plan, or if Disability Waiver of Premium is to be added, complete the Declaration of Insurability form in addition to other requirements for term conversions.

❑ I request a conversion of my Term Policy.
❑ I request a conversion of a Term Rider.

Present Plan Code _____ Current Amount $ _____

New Plan Code _____ Amount $ _____

If the New Plan Code is a Universal Life Policy, please elect a Death Benefit Option:
❑ A – Specified Amount
❑ B – Specified Amount + Accumulation Value
❑ C – Specified Amount + Return of Premiums Paid (Complete Declaration of Insurability)
If no Death Benefit Option is elected, option A is the default option.

If converting only a portion of your current coverage, will the current coverage remain in force? ❑Yes ❑No

REQUIRED - COMPLETE THE FOLLOWING ITEMS IF CONVERTING TO A SPOUSE, OTHER INSURED, OR CHILD TERM RIDER

Owner of new policy _____ Relationship to Rider Insured _____

Owner SSN _____ Address _____

Owner Telephone Number _____ Owner Date of Birth _____

* If you wish to change the beneficiary, please complete the appropriate beneficiary form.

❑ 2. RIDERS AND SUPPLEMENTAL BENEFITS:

For any box "A," complete the Declaration of Insurability Form and provide information for the Proposed Insured(s) below. Check box **A** for Add or Increase; box **C** for Continuation of Benefits from Conversion; box **D** for Delete; or box **R** for Reduce. For increases, show only the amount of the increase.

A C D R
❑ ❑ ❑ ❑ Spouse Term Rider Amount $ _____
Name _____
❑ ❑ ❑ ❑ Children's Level Term Rider _____ Units
❑ ❑ ❑ ❑ Other Insured Term Insurance Rider Amount $ _____
Name _____
❑ ❑ ❑ ❑ Other (Specify Plan Code) _____

A C D R
❑ ❑ ❑ ❑ Disability Waiver of Premium
❑ Guaranteed Increase Option Rider (Complete section 7 when exercising the rider)
❑ ❑ ❑ ❑ Level Term Life Insurance Rider Amount $ _____

OTHER PROPOSED INSURED(S)	Relationship to Primary Insured	Age	Date of Birth Mo./Day/Yr.	Birth State/ Place of Birth	Gender (M / F)	Height (Ft./In.)	Weight (Lbs.)	SSN
A.								
B.								
C.								
D.								

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Is any Other Proposed Insured(s) NOT living at the same address as the Primary Insured? ❑Yes ❑No
If "Yes," provide the address and telephone number:

Current Address _____ Telephone # (_____) _____

Have any of the above Other Proposed Insureds used tobacco or nicotine in the past 12 months? ❑Yes ❑No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine.)
If "Yes," which one(s): _____

❑ 3. INCREASE POLICY SPECIFIED AMOUNT BY: $ _____ (Amount) Effective Date _____

IMPORTANT NOTE:

- **Complete the Declaration of Insurability Form.**
- **If your policy includes the Coverage Continuation Rider, increases in Specified Amount are not permitted. If you choose to proceed with your request for an increase in Specified Amount, the Coverage Continuation Rider will terminate.**
- **Your billable premium may need to be increased, if required, to pay for a higher cost of insurance charge and to maintain your Policy. If billable premium is to be changed, please complete the Premium Information Section, section 9.**

❑ 4. DECREASE POLICY SPECIFIED AMOUNT BY: $ _____ (Amount) Effective Date _____

NOTE: If billable premium is to be changed, please complete the Premium Information, section 9.

❑ 5. CHANGE IN CLASS

❑ Change in Rate Class (i.e. from Standard to Preferred, removal of additional ratings)
Complete Declaration of Insurability

❑ Change in Tobacco/Nicotine use Class (i.e. from Tobacco/Nicotine User to Tobacco/Nicotine Non-User)
Collect Oral Fluid Test (OFT) or schedule urinalysis

Date last used nicotine products: _____

❑ 6. CHANGE UNIVERSAL LIFE DEATH BENEFIT OPTION Effective Date _____

❑ From Option A (Level) to Option B (Increasing). Specified Amount may be decreased.
❑ From Option B (Increasing) to Option A (Level). Specified Amount may be increased.
❑ From Option C (Specified Amount plus Return of Premiums Paid) to Option A (Level). Specified Amount may be decreased.

IMPORTANT NOTE:

- **If your policy includes the Coverage Continuation Rider, only Death Benefit Option A is permitted. If you choose to proceed with your request for a change of Death Benefit Option, the Coverage Continuation Rider will terminate.**

❑ 7. EXERCISE BENEFIT

Evidence of insurability must be provided if you are requesting an increase for more than the maximum amount under the rider.

❑ Guaranteed Increase Option Rider
❑ Regular Option Date
New Specified Amount resulting from increase $ _____
❑ Alternate Option Date (If Alternate Option Date - Enclose Evidence)
❑ Spouse ❑ Child

❑ 8. OTHER CHANGES (NOT for Beneficiary Changes. Recommended for ownership changes. The name, address, telephone number, date of birth and SSN is required when this section is used for ownership changes.) _____

_____

❑ 9. PREMIUM INFORMATION SECTION (Complete only if current premium information is to be changed.)

A. Billable Premium: Life $ _____ Total amount of premium paid with application $ _____

B. Mode: ❑ Annual ❑ Semiannual ❑ Quarterly ❑ Monthly (not available for the Direct method of payment.)

C. Method: ❑ Direct: *(Fill in name and address where premium notices are to be sent, ONLY IF OTHER than those of the Owner.)*

Name
| _____

Number/Street City
| _____ | _____

State ZIP Country
| _____ | _____ | _____

❑ Electronic fund transfer (EFT): *(Complete "Electronic Fund Transfer" section and attach a void check.)*
❑ Salary deduction: Name Number
| _____ | _____
❑ Biweekly Amount | _____
❑ Government allotment: Payee name
| _____
❑ A. Copy of certified allotment submitted with application
❑ B. Certified copy of Form ANY-902 completed in lieu of allotment copy
❑ C. Cash with application — No allotment copy
❑ D. C.O.D. — Defer issue until allotment begins
Rank | _____ Branch | _____ Social Security number | _____
Special dating instructions: Issue age | _____ Issue date | _____

❑ 10. ELECTRONIC FUND TRANSFER

Name of premium payor who will pay premium | Social Security Number
_____ | _____

Name(s) of insured(s)
_____

Account Number: ❑ Checking ❑ Savings | Specify desired date for draft against account
_____ | _____

Bank Name | Branch Name | 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. 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 American National Life Insurance Company of New York subject to their being honored upon presentation.

Date: Month/Day/Year | Signature of Premium Payor
_____ | X _____

Agent
X _____

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DECLARATIONS AND AGREEMENTS

This policy change application consists of this form and, if required, the Declaration of Insurability Form. Each of the undersigned represents for themselves: 1) the completed policy change application and Declaration of Insurability Form (if required), will be attached to and made a part of the policy; 2) the statements and answers given above are full, true and complete to the best of each undersigned's knowledge and belief, and are given to induce American National Life Insurance Company of New York, hereinafter referred to as "the Company," to make the requested policy changes; 3) the requested policy changes will be effective when all the following conditions are met: (a) evidence of insurability, satisfactory to the Company is submitted, if required; (b) any premium required as a result of the requested change is paid in full; (c) the Company consents to the requested policy changes as evidenced by the Registrar's signature below (if the Company is unable to consent to the requested policy changes, we will communicate this decision and the reasons for this decision to the Owner in writing); and (d) the revised policy or new policy, if requested, is delivered to the applicant/owner during the lifetime of the insured(s) and continued insurability at standard rates of all persons affected by the policy change; 4) any existing benefit which is converted in accordance with this application will terminate on the effective date of the new benefit; 5) no change in (i) insurance amount, (ii) risk classification, (iii) insurance plan, (iv) benefits, or (v) premium will be effective unless agreed to in writing by the undersigned; 6) the Company will not be bound by any information not revealed in this Application; and 7) no agent or other representative of the Company except the President, a Vice President, or the Secretary has authority to waive any provision or condition of this agreement or to alter or amend it in any way.

Dated at _____

this _____ day of _____, _____
Month Year

X _____
Signature of Owner

X _____
Signature of New Owner - if applicable

X _____
Signature of Insured - if different than Owner

Witnessed by _____
(Soliciting Agent or Disinterested Party)

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK hereby consents to the policy changes requested herein. Any amendment, correction, or additions required will be provided to the Owner for acceptance with this endorsed application for policy change. This application for policy change is dated at the Administrative Office of American National Life Insurance Company of New York as of the date shown below. This form, and any supplements used therewith are hereby attached to and made a part of this policy.

Hereby agreed to and accepted by:

_____
Registrar

J. Mark Flippin
Secretary

on _____, _____
Month/Day Year