

Underwritten By:



AMERICAN NATIONAL LIFE INSURANCE  
COMPANY OF TEXAS  
Galveston, Texas

## Enrollment Form for Adult Group Accident Medical Insurance

1. Name of Policyholder \_\_\_\_\_

2. Address \_\_\_\_\_  
Number Street City State Zip

3. Policy term requested: 12 months beginning \_\_\_\_\_, 20\_\_\_\_\_.

4. Policy to cover:  All Members

5. Plan of Benefits and Premium Rates (Check Plan selected):  Excess  Primary

Check Plan Number	Accidental Death Benefit	Maximum Medical Benefit	Deductible Amount	Annual Rate Per Person	
				Excess Plan	Primary Plan
<input type="checkbox"/> 1	\$1,000.00	\$2,500.00	\$None	\$2.00	\$2.70
<input type="checkbox"/> 2	1,000.00	2,500.00	25.00	1.65	2.25
<input type="checkbox"/> 3	1,000.00	2,500.00	50.00	1.45	1.95
<input type="checkbox"/> 4	2,500.00	5,000.00	None	2.50	3.40
<input type="checkbox"/> 5	2,500.00	5,000.00	25.00	2.20	3.10
<input type="checkbox"/> 6	2,500.00	5,000.00	50.00	1.95	2.60
<input type="checkbox"/> 7	5,000.00	10,000.00	None	3.25	4.30
<input type="checkbox"/> 8	5,000.00	10,000.00	25.00	2.95	3.80
<input type="checkbox"/> 9	5,000.00	10,000.00	50.00	2.70	3.50
<input type="checkbox"/> 10	5,000.00	15,000.00	None	3.70	4.85
<input type="checkbox"/> 11	5,000.00	15,000.00	25.00	3.50	4.65
<input type="checkbox"/> 12	5,000.00	15,000.00	50.00	3.35	4.45

6. Policy Premium:

Number of members \_\_\_\_\_ x Premium rate of \$ \_\_\_\_\_ = \$ \_\_\_\_\_ Total Premium\*

\*Minimum Policy Premium for Excess Coverage is \$150.00

\*Minimum Policy Premium for Primary Coverage is \$200.00

**Premium is fully earned on the effective date of coverage. No pro-rata refunds will be made.**

7. I understand and agree that (a) If this application is accepted by the Company, coverage will begin on the date of acceptance or on the date requested in Question 3, whichever is later, subject to the payment of the required premium, and (b) no contribution to the premium will be made by an Insured Person. Premium computation is subject to audit.

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

Policyholder, by \_\_\_\_\_

Title or Position \_\_\_\_\_ Date Signed \_\_\_\_\_

Agent/Broker Name and Address: