

GROUP NO. 141196-	EMPLOYER UNIT ADDRESS	NORTH EAST INDEPENDENT SCHOOL DISTRICT			CERT. #	
Name of Individual Applicant _____				<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth
Last _____ First _____ Middle _____				<input type="checkbox"/> Single	<input type="checkbox"/> Married	Mo. Day Year
social Security Number _____					NEISD USE ONLY	
Payroll <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	Date Employed _____	Occupation _____				
Name of Beneficiary _____				Relationship _____	Effective Date	
(if Female, above as Mary Doe rather than Mrs. John Doe)						
Show Desired Breakdown of Total Insurance Amount	Basic Group Term Life \$ _____	AD&D \$ _____	Amt. of Opt. Group Life \$ _____	If option group term Insurance is desired		
<p>1 hereby request the insurance coverage as indicated above and for which I am or may become eligible under the insurance Policy Of Policies issued by the American National Insurance Company and authorize the deduction from my earnings of the amount required to cover my share of the premiums, if any. My Insurance shall take effect on the date provided in the Policy If I am actively at work a minimum of 20 hours per week performing all my usual duties at my customary Place of employment on that date. I have the right to revoke this deduction authorization at any time by written notice.</p>						
Date Signed	Signature of Individual Applicant			Date Received IN H/O		

Form 5519

AMERICAN NATIONAL INSURANCE COMPANY

STATEMENT OF HEALTH - The following information is submitted as evidence of my insurability.

- 1 - Within the past five years, have you been confined to a hospital or similar institution, or have you undergone any surgical operations or medical treatment? Yes No
2. Have you ever been advised to have, or do you contemplate having, any hospitalization or surgical procedure for yourself? Yes No
3. Have you ever been declined, rated or postponed for life insurance? Yes No
4. To the best of your knowledge, are you free of any impairment or disease? Yes No
5. State your exact weight _____ lbs. and height _____

If the answer to 1, 2 or 3 is "yes", or 4 is "no", please explain -

I certify that the above information is true and complete to **the best of my knowledge.**

Date _____ Applicant's Signature _____

ALL QUESTIONS ON PAGE 2 MUST BE ANSWERED COMPLETELY OR APPLICATION WILL BE DECLINED

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**Evidence of Insurability
AMERICAN NATIONAL INSURANCE COMPANY, GALVESTON, TEXAS**

This form accommodates you (the applicant-the employee/member) and your eligible dependents. If you are applying for yourself only, disregard all reference to dependents. If you are already insured and are applying for your eligible dependent(s) only, complete questions 1 and 2 regarding yourself, and questions 4-10 with respect to your eligible dependents only.

I hereby apply to American National Insurance Company for insurance on the individuals named in 4 below. This application is for insurance under the policy numbered below, under which such individuals are eligible for insurance. The following statements are made as inducement to American National Insurance Company to consider issuing the insurance for which I am making application:

Group No 141196 Unit No. _____ Employee Social Security No. _____

1. Employers Name-_____ Department _____

2. Name of Employee _____ Date _____ Occupational Duties _____
Employed _____

Employee's Residence: Street and No-_____ City and State _____

3. Name of Employee's Beneficiary _____ Relationship _____

4. List all persons proposed for Insurance: (THIS MUST INCLUDE EMPLOYEE) (if space is insufficient, continue on reverse side)

Names of Employee and Dependents	Relationship to Employee	Place of Birth	Date of Birth	Sex	Height		Weight
					ft.	in.	

5. Have you or any of your named dependents ever had any of the following: NO YES. IF YES, INDICATE WHICH ONES BY CIRCLING AND GIVE NAME AND DETAILS IN #6 BELOW. Albumin or Sugar in Urine, Arthritis, Asthma, Abnormal Blood Pressure, Cancer, Diabetes, Dizziness, Epilepsy, Fainting Spells, Goitre, Heart Trouble, Hemorrhage, Kidney Trouble, Liver Trouble, Mental Illness, Nervous Disorder, Paralysis, Pleurisy, Shortness of Breath, Spinal Trouble, Stomach or Duodenal Ulcer, Syphilis, Tuberculosis, Tumor, an Immune Deficiency Disorder, AIDS, the AIDS related complex (ARC) or test results indicating exposure to the AIDS virus?

6. Clinical History: Give below full details of any illness, injury, operation or condition you or any of your named dependents have had in the last 5 years. (IF NONE, SO STATE) (Note: If additional space is needed, use separate sheet of plain paper and so state below.)

Name of Patient	Nature of Condition Treated	Date of Onset		No. of Attacks	Duration	Date Operation Performed	Name and Address of Attending Physician
		Mo.	Yr.				

7. Is any person proposed for insurance presently consulting a physician? _____ If so, give name(s) and details _____

8. Has any person proposed for insurance every been refused, postponed or rated-up by a life or health insurance company? _____
(If so, give name of person, name of company, date and cause.) _____

9. If insurance now applied for was not taken when first eligible, give reason. _____

10. Name and address of Family Physician: _____

SECTION 606(a) OF THE FAIR CREDIT REPORTING ACT REQUIRES THE FOLLOWING NOTICE: In making this application for insurance, it is understood that an investigative consumer report may be prepared whereby information is obtain through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

I hereby declare that all statements and answers to questions in this application are complete and true to the best of my knowledge and belief and are made as a consideration of the insurance herein applied for; and I agree that the insurance issued thereon shall not take effect unless on the date thereof health of myself and my eligible Dependents is the same as described herein and that in no event shall the insurance be in force except as provided in the Group Policy or Policies under which this application is hereby made. I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health to give to the American National Insurance Company any such information about me, my spouse and my children with reference to us, our health and medical history and medical history and my hospitalization, advice, diagnosis, treatment, disease or ailment. I understand that any fees charged for any information requested relating to this application are my responsibility. I have received notification describing the Medical Information Bureau. To facilitate rapid submission of such information, I authorize all the above sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the American National Insurance Company to collect and transmit such information. A picture copy of this authorization shall be as valid as the original. I hereby authorize my Employer to deduct from any salary, commissions, or other amounts payable to me, an amount sufficient to cover any premium payments due American National Insurance Company, Galveston, Texas from me under the Group Plan or Plans. I acknowledge that I have completed this Statement of Physical Condition, and having read the reverse side thereof, I have, by my signature below, authorized the Medical Information Bureau to give to American National Insurance Company, Galveston, Texas, any information it may have.

Dated at _____ the _____ Day of _____ 19____

Witness: _____ Applicant: _____

Witness: _____ Spouse: _____