Mature Age Supplement

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720 Business (800) 672-9960 Fax (409) 766-6589

Complete if Proposed insured is 71 or older

Proposed Insured: _____ Date of Birth: _____

1) Does the Proposed Insured drive? ____ Yes ____ No (If no, provide details of when and why they stopped driving) _____

2) Does the Proposed Insured participate in any exercise program? ____ Yes ____ No (If yes, what type and how often?) _____

3) Delayed Word Recall: Point to 3 objects and ask the Proposed Insured to tell you what they are and advise that you will be asking him/her to recall these later. Record the 3 objects: 1) _____ 2) _____ 3) _____

4) Does the proposed insured use any device to assist with walking (cane, crutches, walker) or use a wheelchair? ____ Yes ____ No (If yes, provide details) _____

5) Does the proposed insured have a history of falls? ____ Yes ____ No (If yes, provide details) _____

6) Is there any evidence that the Proposed Insured has a cognitive disorder (confusion, lack of comprehension, changes behavior)? ____ Yes ____ No (If yes, provide details) _____

7) Have the Proposed Insured draw a clock face, mark the hours and draw the hands to show the time 11:10.

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8) **Note:** If "yes" to questions 4 and 5, then omit this question. Otherwise, please record how long it takes for Proposed Insured to complete the following task.
Get up from seated position, walk 10 feet, return and sit again.
Time: _____ seconds for entire process.

9) Ask the Proposed Insured to recall the 3 objects identified earlier. Record response. _____

_____

_____

EXAMINER OBSERVATIONS:

10) Describe the Proposed Insured's gait and balance in walking (e.g. very slow, held on to chair for balance, walked briskly without problem, etc.) _____

_____

11) Describe Proposed Insured's ability to sit down (e.g. able to sit in a smooth motion, unable without help, or collapses/ "plops" into chair, etc.) _____

_____

12) Describe Proposed Insured's ability to arise from chair (e.g. able with ease, requires 2 or more attempts, unable to rise without help, etc.) _____

_____

I herby certify that I have personally examined the Proposed Insured and have correctly reported my findings.

Signed at _____
City State

_____ This _____ Day of _____ Year _____

_____ _____
Name of Examiner (MD/DO) Signature of Examiner