AFR LIFE

American Farmers & Ranchers Life Insurance Company

Safeguard Group Term Life Insurance to Age 121

Enrollment Form with Statement of Insurability

Section 1 – Group Information

Employer/Group Name _____ Group Number _____

Section 2 – Employee/Member Information

Employee Member Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/____/_____ Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Are you "actively at work" * ? ☐ Yes ☐ No

*"Actively at Work" means the employee/member is an eligible employee/member of the employer/affiliation through which you are applying for insurance. The employee/member is able to work and to perform the normal activities of a person of like age and gender; and is not confined in a hospital, at home, or elsewhere due to injury or sickness on the date the application is signed.

Section 3 – Employee/Member Coverage (complete only if applying for Employee/Member coverage

Coverage Amount: _____ Premium Mode _____ Premium Amount:_____

Primary Beneficiary: _____ Relationship to Insured: _____SSN: _____ Birth Date: _____

Primary Beneficiary: _____ Relationship to Insured: _____SSN: _____ Birth Date: _____

Contingent Beneficiary: _____ Relationship to Insured: _____ SSN: _____ Birth Date: _____

Contingent Beneficiary: _____ Relationship to Insured: _____ SSN: _____ Birth Date: _____

Section 4 – Dependent Information (complete only if applying for dependent coverage)

The policyholder will be the certificate holder and beneficiary of the dependent coverage unless otherwise noted.

Spouse Name _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/____/_____ **Coverage Amount:** _____ Premium Amount: _____

Primary Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

Contingent Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

Child Term Rider (CTR)

CTR Rider Coverage Amount: _____ Premium Amount: _____

Child 1 Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/____/_____

Child 2 Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/____/_____

Child 3 Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/____/_____

Section 5 - Statement of Insurability

To the best of my knowledge and belief all answers in this Statement of Insurability are true and correctly recorded and are made as a consideration for the applied for insurance.

	Employee		Spouse	
	Yes	No	Yes	No
I. In the past 5 years, has any Applicant been diagnosed, treated, or prescribed medication by a medical professional for AIDS, AIDS related complex or an immune system disorder?	☐	☐	☐	☐
II. In the past 6 months, has the Spouse been unable to work or needed personal or mechanical assistance in walking, bathing, or dressing or been confined at home, been hospitalized* due to injury or sickness, excluding well-baby delivery and treatment for back pain?			☐	☐
III. In the past 5 years, has any Applicant:				
A. Been diagnosed, treated, or prescribed medication by a medical professional for any of the following conditions: any disease or disorder of the heart, stroke, cancer, lung disease, chronic respiratory disorder (including any treatment with oxygen but excluding asthma), diabetes requiring insulin, liver, or kidney disease?	☐	☐	☐	☐
B. Been convicted two or more times of driving under the influence of alcohol or drugs or while intoxicated?	☐	☐	☐	☐
C. Been treated by a medical professional or in a medical facility or received professional counseling for alcohol or drug dependency or been advised to reduce or discontinue use of alcohol.	☐	☐	☐	☐
IV. In the last 10 years, has any Applicant ever applied for and been rejected for life insurance?	☐	☐	☐	☐
V. In the past 12 months has any Applicant had diagnostic testing, surgery, or hospitalizations* recommended by a medical professional which has not been completed or for which the results have not been received?	☐	☐	☐	☐

*Hospitalization is defined as an admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long-term care facility; or receipt of the following treatment wherever performed; chemotherapy, radiation therapy, or dialysis.

SAMPLE

Section 6- Conditions Relating to this Form

Disclosure: This Policy has a 12-month Coverage limitation for death caused by illness. If the Insured person passes away due to illness or disease within 12 months after the effective date of Coverage, We will not pay the death benefit. Instead, We will refund all premiums paid for this Coverage. This applies even if the illness or disease was not known or diagnosed before Coverage started. Deaths caused by accidents are not affected by this limitation.

Agreement: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the applied for insurance. I understand that AFR Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s) and understand that AFR Life will have the right to verify prescription and medical history as part of this process, as needed. AFR Life may rescind the policy in accordance with the Contestability provisions of the Policy due to any material misrepresentation of fact made in this application. Insurance is effective under the policy only when it is delivered to the owner, and then only if the full first premium is paid and all of the statements in this application remain correct and complete.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

I certify I have authorized my employer to make payroll deductions of premiums for myself and my family members OR I certify I have authorized AFR Life Insurance Company to debit my checking account to make premium payments for myself and my family members.

Signature of Employee/Member (Certificate Owner): _____ Date: ____/____ /____

Signed at City: _____ State: _____

Insurance Representative Certification (when Insurance Representative assisted in completion of the application): I certify that I reviewed all questions on this application, and that the answers have been recorded accurately. I know of nothing affecting the insurability of the proposed insured(s) which is not fully recorded on this application.

Insurance Representative Name: _____ Signed in State of _____

Insurance Representative Signature: _____ Date: ____/____ /____

AFR Life Agent Code: _____