AMERICAN FARMERS & RANCHERS LIFE INSURANCE COMPANY

4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125 (800) 425-9303

Advantage Term—Renewable Level Term Insurance

PROPOSED INSURED

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ E mail: _____

SSN: _____ Driv. License #: _____

Occupation: _____ Income/mo.: $_____

Age: _____ Birthdate: ___/____/_____ Sex: _____

Height: _____ Weight: _____ Change Past 12 mos. _____

Cause of weight change: _____

Maiden Name (married female): _____

POLICYOWNER

PRIMARY OWNER (if different from Insured)

Name: _____ SSN: _____

Address: _____

City: _____ Zip: _____ Birthdate: _____

Phone: _____ E mail: _____

CONTINGENT OWNER (If Primary Owner dies before Insured)

Name: _____ SSN: _____

Address: _____

City: _____ Zip: _____ Birthdate: _____

Phone: _____ E mail: _____

BENEFICIARY

□ Per Stirpes

PRIMARY BENEFICIARY

Name: _____ Birthdate: _____

Relationship: _____ SSN: _____

Name: _____ Birthdate: _____

Relationship: _____ SSN:_____

CONTINGENT BENEFICIARY

Name: _____Birthdate: _____

Relationship: _____ SSN: _____

Name: _____ Birthdate:_____

Relationship: _____ SSN: _____

PLAN & RIDERS

Policy Face Amount ($250,000 max.): $_____

Plan Term: ☐ 10 Yr. ☐ 15 yr. ☐ 20 Yr. ☐ 30 yr.

☐ Disability Waiver Benefit Rider

☐ Accidental Death Benefit Rider - Amount $_____

PREMIUM & MODE

Premium Amount: $_____

Premium Mode:

Annual ☐ Semi-Annually ☐ Quarterly ☐

Monthly ☐ Monthly Bank Draft ☐

TOTAL INSURANCE IN FORCE

□ None In Force

Insuring Company	Issue Year	Face Amount	Acc. Death Benefit

Will the coverage applied for replace any in force life, annuity or accident and health coverage? Yes ☐ No ☐

If "Yes", please attach replacement paperwork.

PERSONAL PHYSICIAN

Name: _____

Phone: _____

City: _____ State: _____ Zip: _____

Date & reason for last visit: _____

_____

ADDITIONAL INFORMATION

Are you a U.S citizen or currently have a valid U.S. permanent resident green card (attach photocopy)? Yes ☐ No ☐

Have you used tobacco or other nicotine products in any form in the last 24 months? Yes ☐ No ☐

Best Time to call for health questions: Phone: _____

Date: _____ Time: _____ AM ☐ PM ☐

Special Requests: _____

_____

_____

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Please provide details to all "Yes" answers to the health questions in the Remarks Section

HAS ANY PERSON TO BE INSURED EVER HAD, BEEN TOLD THEY HAD OR BEEN CONSULTED OR TREATED BY A PHYSICIAN FOR ANY OF THE FOLLOWING:

a. abnormal ECG or blood pressure (high or low), chest pain, elevated cholesterol, coronary artery disease, stroke, Transient ischemic attack (TIA), peripheral vascular disease or disorder of the heart, blood vessels or of the cerebrovascular system? ☐ Yes ☐ No

b. cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles or lesions, dysplastic nevi, malignant melanoma or any other malignancy, or any growth or lump that has not been evaluated by a physician? ☐ Yes ☐ No

c. diabetes, thyroid disorder, anemia, hepatitis or any other blood or glandular disorder? ☐ Yes ☐ No

d. any disorder of the stomach, intestines, rectum, liver, or pancreas, kidney or bladder? ☐ Yes ☐ No

e. lupus, connective tissue disease, or any injury to or disease of the bones, muscles, joints, eyes, or skin? ☐ Yes ☐ No

f. epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's or any other disease or disorder of the nervous system? ☐ Yes ☐ No

g. anxiety, depression, or an emotional, behavioral, mental or nervous disorder? ☐ Yes ☐ No

h. any disease, disorder, or abnormal screening or diagnostic tests related to the breast or reproductive organs? ☐ Yes ☐ No

i. any ear, nose, throat, lung disorder, or any respiratory disorder, to include sleep apnea? ☐ Yes ☐ No

j. AIDS (acquired immune deficiency syndrome), positive HIV test or any other immunological disorder? ☐ Yes ☐ No

OTHER THAN ITEMS STATED ABOVE, HAS THE PROPOSED INSURED WITHIN THE PAST 5 YEARS:

a. consulted, received treatment or advice from, been prescribed medication by any other medical advisor? ☐ Yes ☐ No

b. had any abnormal diagnostic or screening tests or within the past 2 years been advised to have any diagnostic test, hospitalization, surgical procedure or treatment that has not been done? ☐ Yes ☐ No

c. been aware of any symptoms for which a medical advisor has not yet been consulted? ☐ Yes ☐ No

d. engaged in hang gliding, parachuting, scuba diving, automobile, power boat or motorcycle racing, or other hazardous sports, avocations or hobbies or intend to do so? ☐ Yes ☐ No

e. had an application for insurance declined, rated or postponed? ☐ Yes ☐ No

f. used or is currently using marijuana, narcotics, intravenous drugs, cocaine, barbiturates, hallucinogens, or been treated for drug or alcohol abuse or been advised by a doctor to limit the use of alcohol or any medication prescribed or not? ☐ Yes ☐ No

g. been on parole or probation, charged with a felony or misdemeanor or awaiting trial for a felony? ☐ Yes ☐ No

h. been charged with a driving while impaired (alcohol, drugs, other) violation, had drivers license revoked or suspended, or within the last 24 months received 3 or more citation for moving violations? ☐ Yes ☐ No

i. flown as a pilot, student pilot or crewmember of any aircraft or have intentions to do so? ☐ Yes ☐ No

REMARKS: Give details of "Yes" answers to items listed above, by listing question no., disorder, date, duration, names/address of physicians & hospitals.

_____

_____

_____

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DISCLOSURES, AGREEMENTS AND AUTHORIZATIONS

On my own behalf as well on the behalf of anyone who is proposed for insurance in this application, **I declare and agree** to the following: 1. All statements in this application are complete and true to the best of my knowledge. 2. This application and any supplement forms, together with the policy issued, constitutes the entire contract. 3. No liability or coverage under any insurance policy exists unless American Farmers & Ranchers Life (AFRL) approves the application and issues a policy. 4. Only the President/CEO of AFRL, the Secretary of AFRL, or the Board of Directors of AFRL can make, modify or discharge contracts. 5. Only the President/CEO of AFRL, the Secretary of AFRL, or the Board of Directors of AFRL can waive AFRL's rights or requirements. 6. Any person who examines this application or policy, either now or later, is free to share the information contained in this application or policy in furtherance of legitimate business. 7. The owner of the policy will be the proposed insured unless another person is named as the owner. 8. I will, when required by AFRL, answer health and activity questions in a telephone interview with AFRL staff to complete the "Supplemental Form", which will be considered a part of the life insurance contract.

Authorization To Obtain or Disclose Information

For underwriting and claim purposes, **I authorize any of the following persons or entities** to disclose Protected Health Information and personal details to American Farmers & Ranchers Life (AFRL) or AFRL's reinsurers: 1. Health Care Providers as defined by HIPAA. 2. Mental health providers. 3. Covered Entities as defined by HIPAA. 4. Business Associates of Covered Entities. 5. Pharmacy. 6. Governmental Agencies. 7. Pharmacy benefits manager. 8. MIB, Inc. 9. Life, Health, Accident, Property or Casualty Insurance Companies. 10. Re-Insurance Companies. 11. Any other person possessing Protected Health Information or personal details about me or the proposed insured.

I understand that Protected Health Information or personal details could include any of facts, details and records about the following: 1. Physical and mental health. 2. Records relating to mental and physical health. 3. Records relating to physical and mental activities and limitations. 4. Billing and financial records. 5. Prescription records. 6. Diseases such as Hepatitis, Gonorrhea, HIV, or AIDS. 7. Psychiatric and mental health* records. 8. Records relating to depression, addiction, chemical dependencies, and medications. 9. Hobbies and recreational activities. 10. Flying, transportation habits, and driving record. 11. Crimes. 12. Financial details.

I intend this authorization to be as broad as allowed by law, including HIPAA. I understand that Protected Health Information might contain information for conditions or treatments that I find embarrassing or that I otherwise would not want disclosed. I understand that sometimes records contain information for conditions that is intermixed with other records and cannot be segregated. Despite this, I agree to the sharing of any and all Protected Health Information. I agree that this authorization can be cancelled by me at any time except to the extent that action has already been taken in reliance on it. I understand I may cancel this authorization in writing sent to the company address listed on the disclosure form. A photocopy of this form shall be as valid as the original. I agree that after these details are disclosed, the recipients may re-disclose the details resulting in loss of protection by federal regulations. This authorization will be valid for 24 months from the date shown below.

PSYCHIATRIC AND MENTAL HEALTH RECORDS: Title 43A, Section 1-109 of the Oklahoma Statutes, provides that mental health and drug and alcohol abuse records are confidential and privileged. A provider may disclose such records only upon a written authorization signed by the patient or a Court order meeting the requirements of that statute.

Authorization to Disclose Details to MIB, Inc.

I authorize AFRL, or its reinsurers, to disclose Protected Health Information and personal health and activity details to MIB, Inc. in the form of a brief coded report for their fraud prevention programs. All such sources except MIB, Inc., may give these facts to any support organization which has been authorized by AFRL to collect and transmit them. I have the right to receive a copy of this.

Agreement to Release AFRL

I intend for AFRL to gather Protected Health Information and personal details about me or the person proposed for insurance. I understand that AFRL may, from time to time, share this information to others in furtherance of this application or in furtherance of insurance. Therefore, I release AFRL and AFRL's agents, employees, and officers from any legal liability that may arise from these DISCLOSURES, AGREEMENTS AND AUTHORIZATION. I waive all rights and privileges under law relating to Disclosure of Confidential Information, Defamation, and Invasion of Rights of Privacy. I have received the notice of disclosure of information which tells about MIB, Inc., and the notice to persons applying for insurance called for by the Fair Credit Reporting Act.

AGENT REPORT AND SIGNATURES

Did you complete this form in person? Yes ☐ No ☐

Is proposed insured a relative? Yes ☐ No ☐

Are you aware of anything not disclosed which might affect the approval of this risk? Yes ☐ No ☐

_____

Location Application Was Signed (City-State)	Date	Signature of Proposed Insured
Signature of AGENT as WITNESS	Agent's Number	Signature of Owner (if other than Proposed Insured)

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Customer Notice

AGENT: This Customer Notice is to be given to the proposed insured before the application is completed.

As part of our method for processing your insurance request, a background report may be requested for personal details through interviews with your neighbors, friends, or others who know you. These questions are about your character, reputation, personal traits and mode of living. You have the right to make a written request to receive details about the nature and scope of these questions. For these details, you may write to **American Farmers & Ranchers Life Insurance Company, 4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125.** This notice is in accordance with the Fair Credit Reporting Act (Public Law 91-508).

Details about your personal life will be treated as confidential. American Farmers & Ranchers Life Insurance Company, or its reinsurer(s) may, however, make a brief report of health details to MIB, Inc., a not-for-profit group for member insurance companies, which collects and shares details with its members. If you apply to another MIB company for life or health insurance coverage, or submit a claim for benefits to this company, MIB, may supply such company with the details about you in its file.

If you request it, MIB will provide any details in your file. (Medical details will be disclosed only to your primary physician.) If you have any questions about the accuracy of details in MIB's file, you may contact MIB and seek to correct the item according to the rules set forth in the federal Fair Credit Reporting Act. The address of the MIB office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can call MIB at 866-692-6901.

American Farmers & Ranchers Life Insurance Company, or its reinsurer(s), may also share details in its file with other life insurance companies where you may apply for life or health insurance, or where you make a claim for benefits.

You may revoke the authorization to disclose nonpublic personal health information at any time. To make this revocation, you may submit your request in writing to **American Farmers & Ranchers Life Insurance Company, 4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125.**

AUTHORIZATION FOR DIRECT PAYMENT – BANK DRAFT FORM

I authorize American Farmers & Ranchers Life and the bank or financial institution named below to deduct insurance payment from my checking or savings account. If any deduction is not honored by my bank or financial institution, the policies will be considered not paid. I may discontinue this plan by contacting American Farmers & Ranchers Life in writing. I can stop payment of any entry by notifying my financial institution 3 days before my account is charged.

Name of Financial Institution _____

Branch _____

City _____ State _____ Zip _____

Account No. _____ Checking ☐ or Savings ☐

Financial Institution (ABA) Routing Number _____

(between these symbols ⑈: ⑈: on the bottom left of your check)

Name of Payor (Please Print) _____

Address of Payor (Please Print) _____

City _____ State _____ Zip _____

Policy Numbers _____

Preferred Day of the Month to Draft (Select one date between the 1st and 28th) _____

*Please note that you will not receive any further notice concerning the amount being drafted from your account unless the amount of the draft changes.

Signature of Payor _____ Date _____

PLEASE ATTACH A CHECK MARKED "VOID" HERE

American Farmers & Ranchers Life insurance Company

4400 Will Rogers Parkway
Oklahoma City, OK 73108

P.O. Box 25968
Oklahoma City, OK 73125