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: _____

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

Coverage Amount: _____ Premium Mode (M, Q, SA, A) _____ Premium Amount:_____

Primary 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) eligible ages 14 days through 19 years, 26 if full time student

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: ____/_____/_____

Child 4 Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/_____/_____

Child 5 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.

Section 6- Conditions Relating to this Form

Representations:

Agreement: I attest that in the absence of my spouse, I, as Owner, have the appropriate knowledge to answer the questions for my spouse and children. I represent that all statements and answers in this application are complete, true and correctly recorded TO THE BEST OF MY KNOWLEDGE AND BELIEF without assistance, direction or assurances regarding my eligibility for coverage from anyone. I understand that AFR Life Insurance Company (AFR Life) 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. The statements and answers in the application are the basis for any policy issued and no information about me shall be considered to have been given to AFR Life unless it is stated in the application, and I will notify AFR Life of any changes in the statements or answers given in the application between the time of application and delivery of the policy.

I agree that 1) upon approval of this application by AFR Life, it and the Policy issued to me will describe the benefits and terms of coverage ; 2) coverage applied for will not become effective until approved by AFR Life and is subject to each covered person's health being as described in this application, and upon receipt of the full first premium, in which case the coverage shall take effect as of the effective date as shown in the Policy; 3) if within 60 days of receipt of all required documentation this application is not approved, it will become void and any premiums paid will be refunded; I will be so notified.

Note: No benefit will be paid and premiums will be refunded if the insured's death is caused or contributed to by any attempt at suicide, or intentionally self-inflicted injury, while sane or insane. Refer to your Policy for coverage details. 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.

I authorize any physician, hospital, clinic, pharmacy, other medical facility, insurance, or reinsuring company, the MIB, Inc., consumer reporting agency, employer or other organization, institution or person having information available as to diagnosis, treatment and prognosis with respect to any other information of me, to give to AFR Life or our legal representative including third party administrators, any and all such information. Any information obtained will not be released by AFR Life to any person or organization EXCEPT to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my Application, claim, other business purposes, or as may be otherwise lawfully required or as I may further authorize. I know that I may request to receive a copy of this Authorization. A photographic copy of this Authorization shall be as valid as the original. This Authorization shall be valid for 30 months. The Application Date is shown below. I understand that the agent cannot accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the Application or the Policy to which it applies.

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

By signing below, I/We or my authorized representative agree to receive all documents and correspondence electronically and that I/We can access the internet, or the email address provided. I/we understand that I/We may revoke this authorization or request specific paper documents without revoking this authorization by contacting American Farmers & Ranchers Life Insurance Company by mail, email, or telephone.

If this Enrollment form is completed electronically, I/We agree that My/Our electronic signature serves as my/our original signature. If this Enrollment form is not completed electronically, I/We agree to I/we are providing verbal consent to certify My/Our Enrollment form in lieu of a signature.

[I certify I have authorized my employer to make payroll deductions of premiums for myself and my family members.] [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: _____

Signature of Spouse (if spouse coverage elected): _____Date: ____/____ /____

Signed at City: _____ State: _____