American Farmers & Ranchers Life Insurance Company

Application for Group Insurance

Admin. Office P.O. Box 25968, Oklahoma City, OK 73125

Application is made to AFR Life Insurance Company (AFR Life) for the insurance coverage(s) indicated below. This Application must be accepted and approved by AFR Life prior to any Contract being in effect.

Employer Information

Full Legal Name of Group Employer: _____

Key Group Contact: _____ SIC Code: _____

Street Address: _____

City/State/Zip Code: _____

Situs State: _____ Phone Number: _____ E-Mail Address: _____

Coverage Information

Proposed Effective Date: _____

Contributory Coverage percentage (employee paid): _____ Noncontributory percentage (Policyholder paid): _____

Number of full-time and part-time employees: _____ Number of full-time employees: _____ Total Eligible employees: _____

Number of employees in their waiting period: _____

Minimum number of hours worked per week to be eligible employees (cannot be less than 16 hours per week) _____

Waiting period for eligible employees: CHOOSE ONE of the following*:

☐ Coverage begins on the first day of the month following _____ days of continuous employment, or

☐ Eligibility begins immediately following _____ days of continuous employment

Coverage Applied for ☐ Safeguard Term Plan-Term to 121 ☐ Other **Bill Type:** ☐ List Bill ☐ Self-Administered ☐ Other

Premium Remittance Frequency ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Other

*** Any employee past their waiting period and eligible for coverage within 60 days of the group's effective date must submit a completed Statement of Insurability. The waiting period cannot exceed 180 days. If 60 or more days are chosen as the waiting period, coverage must begin on the first of the month immediately following the waiting period.**

Agreement

The Policyholder agrees to accept the terms and provisions of the group policy, including its exhibits, riders, endorsements or amendments, if any.

General Conditions

In making this Application, the Employer represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Employer to the proposed Contract. Accordingly, this request will be part of the Contract if accepted by AFR Life.

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Signed at City _____ Signed at State_____ Date of signature _____

Group Employer _____ Tax ID _____

Signature of Authorized Officer/Party_____ Title _____

Witness (please print) _____Witness Signature _____

The writing agent on the insurance applied for is (the agent must be duly licensed as required by law):

Writing Agent or Broker Name (please print)_____ Writing Agent or Broker Signature _____