



*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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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.

**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.

| Employee                 |                          | Spouse                   |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes                      | No                       | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Representations**

**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: 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.**

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: \_\_\_\_\_