

Administrative Office:  
4400 Will Rogers Parkway  
P.O. Box 25968 Oklahoma City, OK 73125  
State of Domicile: Oklahoma

## Group Term Life Insurance to *Age 121 Application*

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:** \_\_\_\_\_ **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.

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"/>

## Section 4- Conditions Relating to this Form

### 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: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

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: \_\_\_\_\_