American Farmers & Ranchers Life Insurance Company

Safeguard Term Plan

Individual Term Life Insurance to Age 121 Application

Section 1 – Policyholder Information

Policy Owner Name/ Proposed Insured: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/_____/_____ Address: _____

City: _____ State: _____ Zip Code: _____ Email Address: _____

Employer Name: _____ AFR Employer Group Number_____

Are you actively at work? * Yes☐ No☐ Date of Hire: _____/_____/_____ Payroll Deduction Mode: Weekly☐ Bi-Weekly☐

Coverage Amount: _____ Premium Amount: _____ Semi-Monthly☐ Monthly☐

Riders (Check all that apply) Disability Waiver of Premium: ☐; Better Living Benefit: ☐; Other☐ _____

Primary Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

Contingent Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

* "Actively at Work" means that you are an eligible employee/member of the employer/affiliation through which you are applying for this individual insurance; you are able to work and to perform the normal activities of a person of like age and gender; and you are not confined in a hospital, at home or elsewhere due to injury or sickness on the date you signed this application.

Section 2 – Dependent Information (complete only if applying for dependent coverage)

The policyholder will be the owner and beneficiary of the dependent coverage unless otherwise noted.

Spouse's Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/_____/_____ **Coverage Amount:** _____ Premium Amount: _____

Riders (Check all that apply) Disability Waiver of Premium: ☐; Better Living Benefit: ☐; Other☐ _____

Primary Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

Contingent Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

The policyholder will be the owner and beneficiary of the dependent coverage unless otherwise noted.

Child 1 Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/_____/_____ (eligible ages 14 days through 23 years) **Coverage Amount:** _____Premium Amount:_____

Primary Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

(Additional Children can be shown on a separate sheet of 8.5"x11" paper.)

Child 2 Name: _____ SSN: _____ Gender (male/female): _____

Birth Date: ____/_____/_____ (eligible ages 14 days through 23 years) **Coverage Amount:** _____Premium Amount:_____

Primary Beneficiary: _____Relationship to Insured: _____SSN: _____ Birth Date: _____

Section 3 – Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity Contracts? Yes☐ No☐

Will the coverage applied for replace any existing life insurance or annuities? Yes☐ No☐

If you answered "yes" to either question, please complete and sign the Notice of Replacement

Section 4-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		Child 1		Child 2	
	Yes	No	Yes	No	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 any Applicant 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 12 months has any Applicant had diagnostic testing, surgery, or hospitalization* recommended by a medical professional which has not been completed or for which the results have not been received?	☐	☐	☐	☐	☐	☐	☐	☐
IV. 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.	☐	☐	☐	☐	☐	☐	☐	☐
V. In the last 10 years, has any Applicant ever applied for and been rejected for life insurance?	☐	☐	☐	☐	☐	☐	☐	☐

***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 5- Acknowledgement, Authorization and Signature

By signing below:

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 24 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.

I acknowledge that I have received or will receive (in the case of solicitation by direct response methods) the Accelerated Benefit Disclosure form(s). I certify I have authorized my employer to make payroll deduction of premiums for myself and my family members.

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.

Signature of Policy Owner: _____ Application Date: ____/____ /____

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.

To my knowledge, the Applicant has existing life insurance or annuity coverage. Yes☐ No☐
If yes, are they replacing existing coverage? Yes☐ No☐

Insurance Representative Name: _____ Signed in State of _____
Insurance Representative Signature: _____ Date: ____/____ /____