

## Application for *Group Insurance*

State of Domicile: Oklahoma

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.

**Any person who knowingly presents a false statement in an application for insurance maybe guilty of a criminal offense and subject to penalties 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 \_\_\_\_\_