AMERICAN FARMERS & RANCHERS LIFE INSURANCE COMPANY
4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125 (800) 425-9303

Customer Notice

AGENT: This Customer Notice is to be given to the proposed insured before the application is completed.

You have the right to make a written request to receive details about the nature and scope of the questions asked on the application. For these details, you may write to **American Farmers & Ranchers Life Insurance Company, 4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125.** This notice follows the Fair Credit Reporting Act (Public Law 91-508).

Details about the insured's personal life will be treated as confidential. American Farmers & Ranchers Life Insurance Company, or its reinsurer(s) may, however, make a brief report of health details to MIB, Inc., a not-for-profit group for member insurance companies, which collects and shares details with its members. If you apply to another MIB company for life or health insurance coverage, or submit a claim for benefits to this company, MIB, may supply such company with the details about you in its file.

If you request it, MIB will provide any details in your file. (Medical details will be disclosed only to your primary physician.) If you have any questions about the accuracy of details in MIB's file, you may contact MIB and seek to correct the item according to the rules set forth in the federal Fair Credit Reporting Act. The address of the MIB office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can call MIB at 866-692-6901.

American Farmers & Ranchers Life Insurance Company, or its reinsurer(s), may also share details in its file with other life insurance companies where you may apply for life or health insurance, or where you make a claim for benefits.

You may revoke the authorization to disclose nonpublic personal health information at any time. To make this revocation, you may submit your request in writing to **American Farmers & Ranchers Life Insurance Company, 4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125.**

AMERICAN FARMERS & RANCHERS LIFE INSURANCE COMPANY

4400 Will Rogers Parkway, P.O. Box 25968, Oklahoma City, OK 73125 (800) 425-9303

Young Driver (eligible age 15 to 25) —10 Year Level Term (Non-renewable)

PROPOSED INSURED

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ E mail: _____

Age: _____ Birthdate: ___/____/____ SSN: _____

PLAN & COVERAGE AMOUNT

Policy Face Amount: $ 25,000

PREMIUM & MODE

Premium Amount: $ 12.00

Premium Mode: Monthly Bank Draft

POLICYOWNER

PRIMARY OWNER (if different from Payor)

Name: _____ SSN: _____

Address: _____

City: _____ Zip: _____ Birthdate: _____

Phone: _____ E mail: _____

CONTINGENT OWNER (If Primary Owner dies before Insured)

Name: _____ SSN: _____

Address: _____

City: _____ Zip: _____ Birthdate: _____

Phone: _____ E mail: _____

BENEFICIARY

☐ Per Stirpes

PRIMARY BENEFICIARY

Name: _____ Birthdate: _____

Relationship: _____ SSN: _____

Name: _____ Birthdate: _____

Relationship: _____ SSN:_____

CONTINGENT BENEFICIARY

Name: _____Birthdate: _____

Relationship: _____ SSN: _____

Name: _____ Birthdate:_____

Relationship: _____ SSN: _____

ADDITIONAL INFORMATION

Is the proposed insured a U.S citizen or currently have a valid U.S. permanent resident green card (attach photocopy)?

Yes ☐ No ☐

TOTAL INSURANCE IN FORCE

☐ None In Force

Insuring Company	Issue Year	Face Amount	Acc. Death Benefit

Will the coverage applied for replace any in force life or annuity or accident and health coverage? Yes ☐ No ☐

If "Yes", please attach replacement form.

MEDICAL QUESTIONS (If any question is answered Yes - Application for Coverage is Declined)	YES	NO
Has the proposed insured been diagnosed or treated by a license member of the medical professions for:		
A. Mental or developmental disorder including severe anxiety or depression, Autism and/or Down's syndrome?	☐	☐
B. HIV, AIDS or AIDS related complex and/or an immune system disorder?	☐	☐
C. Habitual use of: marijuana, narcotics, intravenous drugs, cocaine, barbiturates, hallucinogens or alcohol?	☐	☐
D. Chronic medical condition which has required ongoing care and/or hospitalization (heart, cancer, circulatory, respiratory, infectious disease and/or neurological disorder)?	☐	☐
Does the proposed insured engage in hang gliding; parachuting; scuba diving; automobile, power boat or motorcycle racing; or other hazardous sports; occupations or hobbies or intend to do so?	☐	☐
Has the proposed insured been charged with driving while impaired violation (alcohol, drugs, other); had driver's license/permit revoked or suspended within the past 24 months; or received 3 or more citations for moving violations?	☐	☐

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DISCLOSURES AND AUTHORIZATIONS

On my own behalf or on the behalf of anyone who is proposed for insurance in this application, **I declare and agree** to the following:
1. All statements in this application are complete and true to the best of my knowledge. 2. This application and any supplement forms, and policy issued, constitutes the entire contract. 3. No liability or coverage under any insurance policy exists unless American Farmers & Ranchers Life (AFRL) approves the application and issues a policy. 4. Only the President or CEO of AFRL or the Secretary of AFRL, or the Board of Directors of AFRL can make, modify or discharge contracts. 5. Only the President or CEO of AFRL or the Secretary of AFRL, or the Board of Directors of AFRL can waive AFRL's rights or requirements. 6. Any person who examines this application or policy, either now or later, is free to share the information contained in this application or policy in furtherance of legitimate business. 7. The owner of the policy will be the proposed payor unless another person is named as the owner.

Authorization To Obtain or Disclose Information
For underwriting and claim purposes, **I authorize any of the following persons or entities** to disclose Protected Health Information and personal details to American Farmers & Ranchers Life (AFRL) or AFRL's reinsurers: 1. Health Care Providers as defined by HIPAA. 2. Mental health providers. 3. Covered Entities as defined by HIPAA. 4. Business Associates of Covered Entities. 5. Pharmacies. 6. Governmental Agencies. 7. Pharmacy benefits manager. 8. MIB, Inc. 9. Life, Health, Accident, Property or Casualty Insurance Companies. 10. Re-Insurance Companies. 11. Any other person possessing Protected Health Information or personal details about me or the proposed insured.

I understand that Protected Health Information or personal details could include any of facts, details and records about the following:
1. Physical and mental health. 2. Records relating to mental and physical health. 3. Records relating to physical and mental activities and limitations. 4. Billing and financial records. 5. Prescription records. 6. Diseases such as Hepatitis, Gonorrhea, HIV, or AIDS. 7. Psychiatric and mental health* records. 8. Records relating to depression, addiction, chemical dependencies, and medications. 9. Crimes. 10. Financial details.

I intend this authorization to be as broad as allowed by law, including HIPAA. I understand that Protected Health Information might contain information for conditions or treatments that I find embarrassing or that I otherwise would not want disclosed. I understand that sometimes records contain information for conditions that is blended with other records and cannot be separated. Despite this, I agree to the sharing of any and all Protected Health Information. I agree that this authorization can be cancelled by me at any time except to the extent that action has already been taken in reliance on it. I understand I may cancel this authorization in writing sent to the company address listed on the disclosure form. A photocopy of this form shall be as valid as the original. I agree that after these details are disclosed, the recipients may re-disclose the details resulting in loss of protection by federal regulations. This authorization will be valid for 24 months from the date shown below.

PSYCHIATRIC AND MENTAL HEALTH RECORDS: Title 43A, Section 1-109 of the Oklahoma Statutes, provides that mental health and drug and alcohol abuse records are confidential and privileged. A provider may disclose such records only upon a written authorization signed by the patient or a Court order meeting the requirements of that statute.

Authorization to Disclose Details to MIB, Inc.
I authorize AFRL, or its reinsurers, to disclose Protected Health Information and personal health and activity details to MIB, Inc. in the form of a brief coded report for their fraud prevention programs. All such sources except MIB, Inc., may give these facts to any support organization which has been authorized by AFRL to collect and transmit them. I have the right to receive a copy of this.

Agreement to Release AFRL
I intend for AFRL to gather Protected Health Information and personal details about me or the person proposed for insurance. I understand that AFRL may, from time to time, share this information to others in furtherance of this application or in furtherance of insurance. Therefore, I release AFRL and AFRL's agents, employees, and officers from any legal liability that may arise from these DISCLOSURES AND AUTHORIZATION. I waive all rights and privileges under law relating to Disclosure of Confidential Information, Defamation, and Invasion of Rights of Privacy. I have received the notice of disclosure of information which tells about MIB, Inc., and the notice to persons applying for insurance called for by the Fair Credit Reporting Act.

AGENT REPORT AND SIGNATURES

Did you complete this form in person? Yes ☐ No ☐

Is proposed insured a relative? Yes ☐ No ☐

Are you aware of anything not disclosed which might affect the approval of this risk? Yes ☐ No ☐

_____

Location Application Was Signed (City and State)	Date	Signature of Proposed Insured
Signature of AGENT as WITNESS	Agent's Number	Signature of Payor or Owner (if different from Insured)

AUTHORIZATION FOR DIRECT PAYMENT – BANK DRAFT FORM

I authorize American Farmers & Ranchers Life and the bank or financial institution named below to deduct insurance payment from my checking or savings account. If any deduction is not honored by my bank or financial institution, the policies will be considered not paid. I may discontinue this plan by contacting American farmers & Ranchers Life in writing. I can stop payment of any entry by notifying my financial institution 3 days before my account is charged.

Name of Financial Institution _____

Branch _____

City _____ State _____ Zip _____

Account No. _____ Checking ☐ or Savings ☐

Financial Institution (ABA) Routing Number _____

(between these symbols ⑈: ⑈: on the bottom left of your check)

Name of Payor (Please Print) _____

Address of Payor (Please Print) _____

City _____ State _____ Zip _____

Policy Numbers _____

Preferred Day of the Month to Draft (Select one date) ☐ 7th ☐ 14th ☐ 21st ☐ 28th

Signature of Payor _____ Date _____

PLEASE ATTACH A CHECK MARKED "VOID" HERE

American Farmers & Ranchers Life insurance Company

4400 Will Rogers Parkway
Oklahoma City, OK 73108

P.O. Box 25968
Oklahoma City, OK 73125