Group Life Insurance Record Card

I apply to State Farm Life Insurance Company for group insurance coverage. If I am required to contribute to the cost of insurance coverage, I authorize the deduction from my earnings. I may revoke this authorization at any time by written notice to my employer.

State Farm Life Insurance Company
1 State Farm Plaza, Bloomington, IL 61710-0001

IN ORDER TO RECEIVE THIS BENEFIT, THIS FORM MUST BE COMPLETED IN FULL.

LF-3673-5640
Policy number

Cloverleaf Standardbred Owners' Association Inc.
Business/Organization name

Employee/Member name

Employee/Member Social Security Number

Employee/Member Phone number

Employee/Member home address | City | State | Zip code

Date employed/Date of membership

Job position/duties (if applicable)

Date of birth

Sex: ◯ Male ◯ Female

Annual salary

COMPLETE ONLY IF DEPENDENT COVERAGE IS OFFERED BY THE EMPLOYER/ASSOCIATION AND YOU DESIRE THE COVERAGE

I desire dependent coverage: ◯ Yes ◯ No

My dependents include: ◯ Spouse & children ◯ Spouse only ◯ Children only

Spouse's date of birth

Date of Marriage

Primary Beneficiary(ies)	Date of Birth	SSN	Relationship	Complete address	Phone number	Beneficiary Allocation %
Cloverleaf Standardbred Owners' Association, Inc.				PO Box 156 Temple Hills, MD 20757	301-567-9636	$15,000
						$10,000

Successor Beneficiary(ies)	Date of Birth	SSN	Relationship	Complete address	Phone number	Beneficiary Allocation %

Payment will be made in one sum unless otherwise requested.

Signature

Date (MM/DD/YYYY)

SIGNATURE

WAIVER OF COVERAGE

I do not wish to participate in my employer's/association's group life insurance plan. I understand that if I wish to participate at some future date, evidence of insurability will be required.

Reason for not applying

Signature

Date (MM/DD/YYYY)

SIGNATURE

Please return to State Farm Life Insurance Company, Commercial Group Life Unit, P.O. Box 2380, Bloomington, IL 61702-2380. Fax 309-766-6124

Doc type 80