

# 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