



Send this completed form to:

Administrator, AFA Group Insurance Program
PO Box 14464
Des Moines, IA 50306

QUESTIONS?
Call: 1-800-291-8480

Underwritten by:
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

AFA GROUP TERM LIFE INSURANCE PLAN

NONSMOKER DECLARATION

If you wish to request nonsmoker rates for coverage under this plan for yourself and/or spouse, please complete this Declaration Form and mail it to the Administrator at the address shown above.

Account number: _____

Member's name: _____
FIRST MI LAST

Spouse's name: _____
(if insured) FIRST MI LAST

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home (_____) _____ Work (_____) _____

Member's Social Security Number: _____ - _____ - _____

Date of Birth: Member _____ Spouse _____
MO./DAY/YR. MO./DAY/YR.

Smoking Status:

- Have you used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the past 12 months? Yes No
If "Yes," when did you last use tobacco or nicotine products? ____ / ____
Month Year
- Has your spouse (if insured) used tobacco or nicotine in any form, including nicotine patches nicotine chewing gum and electronic cigarettes, within the past 12 months? (Your spouse must also sign below in order to request the nonsmoker spouse rate.) Yes No
If "Yes," when did your spouse last use tobacco or nicotine products? ____ / ____
Month Year
- Do you understand that these answers may result in a reduced premium and, if such answers are not true, premium contributions will be adjusted to satisfy the higher smoker rates? Yes No

I declare that the information provided in this Declaration is true and complete.

Member's Signature: _____ Date: _____
MO./DAY/YR.

I declare that the information provided in item 2 of this Declaration is true and complete.

Spouse's Signature: _____ Date: _____
MO./DAY/YR.