

Farmers New World Life Insurance Company

Home Office: 3003 77th Avenue S.E., Mercer Island, WA 98040-2890 / (206) 232-8400

Columbus Life Office: PO Box 182325, Columbus, OH 43218-2325 / (614) 764-9975

Variable Policy Service Office: PO Box 724208, Atlanta, GA 31139



FARMERS[®]

LIFE INSURANCE

APPLICATION FOR POLICY CHANGE/REINSTATEMENT

A. Primary Insured Complete all fields. Policy Number:

Name of Primary Insured (First/Middle/Last/Suffix i.e., Jr., Sr.)		Sex M F	Date of Birth	Height	Weight
Residence Address (Street, City, State, Zip Code)			Billing Address If different from Residence Address		
Social Security Number	Driver's License # and State	Occupation	Duties	No. of Years	
Phone #	Does the insured speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment		

B. Additional Insured Complete all fields.

Name (First/Middle/Last/Suffix i.e., Jr., Sr.)		Relationship to Insured	Sex M F	Date of Birth	Height	Weight
Residence Address (Street, City, State, Zip Code)						
Social Security Number	Driver's License # and State	Occupation	Duties	No. of Years		
Does the insured speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment						

C. Policy Owner Requesting Addition or Continuation of Payor Benefits Complete this section and skip to section H.

Name (First/Middle/Last/Suffix i.e., Jr., Sr.)		Relationship to Insured	Sex M F	Date of Birth	Height	Weight
Residence Address (Street, City, State, Zip Code)						
Social Security Number	Driver's License # and State	Occupation	Duties	No. of Years		
Does the insured speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment						

D. Request Complete all sections of this form. Benefits and riders may not be available for all plans in all states.

<p><input type="checkbox"/> Reinstatement</p> <p>Complete and attach the following, if applicable:</p> <ul style="list-style-type: none"> ◆ If the policy is a variable plan, attach the appropriate Variable Application Supplement. ◆ If the policy includes a Critical Illness Accelerated Benefit Rider, complete and attach the appropriate Critical Illness Application Supplement. 	<p><input type="checkbox"/> Policy Change – Add:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Child Rider _____ units <input type="checkbox"/> Waiver of Premium (<i>adult plans only</i>) <input type="checkbox"/> Payor Benefits (<i>juvenile plans only</i>) <input type="checkbox"/> Reduce/Remove rating or extra charge 	<p>Universal Life plans only:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increase Face Amount to \$ _____ Change Death Benefit Option: <input type="checkbox"/> Option A <input type="checkbox"/> Option B <input type="checkbox"/> Waiver of Deduction <li style="text-align: center;"><i>or</i> <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month
<p>If required, is a sales illustration that conforms to this Application for Policy Change/Reinstatement attached? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

E. Supplemental Information Please include all details to any "Yes" answers in the Explanation section below. Use a separate sheet signed and dated, if necessary.

Explanation	Primary Insured	Additional Insured
1. Within the next two years do you plan to travel or work outside of the United States? <i>If "Yes," provide destination and purpose.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you had an application for life, accident or health insurance, or reinstatement of a policy declined, postponed, cancelled or issued other than applied for? <i>If "Yes," provide date(s), type(s) of insurance, final action, and reason(s).</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <i>Questions 3a.-3c. should be answered only for Insureds age 16 and older.</i>		
a. Have you in the last five years used tobacco or nicotine products in any form? <i>If "Yes," provide type of tobacco/nicotine product and date of last use.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you in the last 10 years had your driver's license suspended, revoked, been convicted of driving under the influence (DUI/DWI), or been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you in the last two years, on a professional or amateur basis, flown as a student pilot, pilot or crew member; participated in airborne sports; motor powered racing vehicles; mountain climbing; rodeos, skin or scuba diving; or do you intend to do so in the future? <i>If "Yes," complete the applicable questionnaire.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanation Provide full details, including but not limited to, name of insured, company name, date(s), type(s) of conviction(s) or violation(s), location (city, state, and country), reason(s), and date(s) released from court supervision.

F. Medical Information Please include all details to any "Yes" answers in the Additional Details section below. Use a separate sheet signed and dated, if necessary.	Primary Insured	Additional Insured
1. Have you ever (<i>Georgia, Indiana and Oregon</i> residents provide information for only the past 10 years) had, consulted a physician or other healthcare provider or been treated, hospitalized or taken medication for: cerebral palsy or any congenital or birth disorder; cancer, tumor, mass or any malignant growth; asthma or other respiratory disease or disorder; heart murmur or other heart disorder; seizures or other neurological disorder; diabetes; hepatitis; anemia; or any digestive, kidney or urinary disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you, in the last five years, been admitted or advised to be admitted to any hospital or healthcare facility; or undergone or been advised to have surgery, biopsies, treatment or medical tests that are not included in your answers to the preceding questions above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you, in the last 10 years, had any other illness, disease or injury not included in your answers to any of the preceding questions above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Questions 4a.-4h. should be answered only for Insureds age 16 and older.		
a. Have you ever (<i>Georgia, Indiana and Oregon</i> residents provide information for only the past 10 years) had, consulted a physician or other healthcare provider, been treated, hospitalized or taken medication for: chest pain of any cause; high blood pressure; high cholesterol; heart attack; stroke or other disease or disorder of the brain or blood vessels; sleep apnea; emphysema; liver disease or disorder; memory loss; Alzheimer's Disease; multiple sclerosis; depression; or attempted suicide?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you, in the last 10 years, used or been treated for the use of cocaine, marijuana, heroin, or any other addictive or illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you, in the last 10 years, been advised by a physician or other healthcare provider to reduce or stop drinking alcohol or received treatment of any kind for the use of alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you currently drink alcoholic beverages? <i>If "Yes," provide the number of drinks, cans or glasses per week _____.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have you, in the last five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have you gained or lost more than twenty pounds in the last year? <i>If "Yes", give the amount and cause below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Have you ever (<i>Georgia, Indiana and Oregon</i> residents provide information for only the past 10 years) tested positive for Human Immunodeficiency Virus (HIV) antibodies or antigens? (<i>California</i> residents need only reveal results of HIV tests taken for the purpose of obtaining insurance.).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Have you ever (<i>Georgia, Indiana and Oregon</i> residents provide information for only the past 10 years) had, been diagnosed by a medical professional with, or received treatment for Acquired Immunodeficiency Syndrome (AIDS) or AIDS related complex (ARC), or other immune disorder? (<i>California</i> residents provide information regarding "other immune disorder" excluding HIV status.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details – When providing details to any "Yes" answers, give **patient's name, specific disorder and date of diagnosis**. Include **Physician's and/or Hospital's name, address, telephone number, and date of last visit**. Also list any **medications, tests and treatments** prescribed.

Primary Insured: Do you have a primary physician or healthcare provider that has not been included in your answers to any of the preceding questions? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name, address, and telephone number :	Additional Insured: Do you have a primary physician or healthcare provider that has not been included in your answers to any of the preceding questions? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name, address, and telephone number :
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G. Children's Insurance Rider Information Complete only for Children's Insurance Rider (list all children to be covered).

Name of Child (<i>First/Middle/Last/Suffix i.e., Jr., Sr.</i>)	Relationship	Date of Birth	Social Security Number	Height	Weight

Has any child ever (*Georgia, Indiana and Oregon* residents provide information for only the past 10 years) had, been treated or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures or any other disease or disorder? Yes No
If "Yes," provide child's name, the name and address of child's physician or healthcare provider, date of last visit, and provide disease or disorder, date of diagnosis, tests and medications prescribed.

H. Payor Benefit Information Complete only for Policy Owner's requesting addition or continuation of Payor Benefits.

Have you, the Policy Owner, in the past two years, received any treatment or medication for, or been diagnosed as having any kind of: cancer or tumor; stroke; drug or alcohol dependency; or any disease or disorder of the heart, liver or kidney or disability, including receiving disability income benefits?..... Yes No
If "Yes," include dates and disorders.

Certification, Authorization and Acknowledgement Signatures

Taxpayer Certification

Under penalties of perjury, I (we), as Owner(s), certify that:

1. The Social Security number(s) shown on this form is my correct taxpayer identification number (TIN) or I (we) am waiting for a number to be issued to me, and
2. I (we) am not subject to backup withholding because: I (we) am exempt from backup withholding; or I (we) have not been notified by the Internal Revenue Service (IRS) that I (we) am subject to backup withholding as a result of a failure to report all interest or dividends; or the IRS has notified me that I (we) am no longer subject to backup withholding, and
3. I (we) am a U.S. person(s) (including a U.S. resident alien).

If any of the answers above are "NO," please initial and date here: _____ then complete, sign and submit an IRS Form W-9 with this Application.

Authorization

I (we) authorize any licensed physician; medical practitioner; hospital, clinic or other medical or medically related facility; insurance company; the Medical Information Bureau; the Veterans Administration or any consumer reporting agency; who possesses any information regarding medical history, care, treatment, advice, including but not limited to information related to HIV, sexually transmitted disease, nicotine use, drug use or treatment, prescription drug history, alcoholism or mental health disorder, or non-medical information, such as motor vehicle, financial and criminal records, pertaining to me (us) to give to Farmers New World Life Insurance Company (FNWL), its reinsurers, and their authorized representatives any such information for the purpose of processing my (our) Application for Policy Change/Reinstatement. I (we) realize that I (we) or my (our) authorized representative have the right to receive a copy of this authorization. A copy of this authorization shall be as valid as the original. This authorization is valid for 24 months from the date shown below. If your state laws address the collection, use and disclosure of HIV/Acquired Immunodeficiency Syndrome (AIDS) related information by Insurers, you will receive a separate notice regarding the collection and disclosure of HIV/AIDS related information if HIV testing is required.

If this form has been completed electronically, I (we) have the right to complete this Application for Policy Change/Reinstatement in non-electronic format. I (we) understand that a portion or all of the data collected to create an Application for Policy Change/Reinstatement may be transmitted and/or retained in electronic format. By signing below, I (we) consent to this transaction by electronic means and confirm that I (we) have not withdrawn my (our) consent. I (we) will receive a paper copy of the Application for Policy Change/Reinstatement with confirmation of the change, if approved, or upon receipt of a written request directed to FNWL.

Acknowledgement

I (we) have read this Application for Policy Change/Reinstatement and understand and agree that all the answers and statements made by me (us) in this Application are, to the best of my (our) knowledge and belief, complete and true, that they are correctly and fully recorded and that no material information or circumstances has been withheld or omitted. I understand that any reinstatement and/or changes requested for this policy are not effective until approved by FNWL. I understand and agree that this Application for Policy Change/Reinstatement shall become a part of the policy. I also acknowledge that the reinstated and/or changed policy may be contested by reason of a fraud or misrepresentation of facts material to this reinstatement and/or change for the same period of time following reinstatement and/or change with the same conditions and exceptions as the policy provides with respect to contestability after original issuance. I (we) have read and understand the Important Notice disclosure statement given to me (us) on this date. I (we) also certify that I (we) have read the Fraud Warnings and Other Notices listed on form 31-4226 for my (our) state of residence, if any.

	Signed		on	
_____	at	_____		_____
Primary Insured Signature (or parent if Primary Insured is a juvenile)		City, State		Month, Day, Year
_____		_____		_____
Additional Insured Signature		City, State		Month, Day, Year
_____		_____		_____
Policy Owner Signature (if other than Primary Insured), and title, if applicable		Policy Owner's Spouse Signature (where required in community property states when a person other than Policy Owner's spouse is named as Primary Beneficiary)		Co-Owner Signature and title, if applicable
_____		_____		_____
Witness		Agent		Agent Code
_____		_____		_____

Important Notice

We appreciate your Application with Farmers New World Life, and want to assure you that your request will receive prompt consideration. As part of our normal procedure for processing your request, an investigative consumer report may be obtained regarding you. The information is secured by an independent inspection company or by Farmers New World Life through personal interviews with your friends, neighbors, business associates, and others with whom you may be acquainted. This report, if obtained, contains information as to personal character, general reputation and mode of living except as may be related directly or indirectly to your sexual orientation. You have a right to be interviewed in connection with this report. Upon written request to us, further information as to the nature and scope of this report will be provided. You may also request a copy of the report. If inaccuracies exist in the report, you have a right to request correction. Corrections will be made upon our receipt of proof of the inaccuracy. Any adverse underwriting decision based on this report will be disclosed to you in writing.

Information regarding your insurability will be treated as confidential. Farmers New World Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired).

Farmers New World Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted during the consideration of a claim.

Fraud Warnings and Other Notices

Please review the warning and/or notice applicable to your state, if any.

Arkansas, Louisiana, and New Mexico – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia – “WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.”

Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii – “For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.”

Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Minnesota – *This applies only to the variable funds of life and annuity policies:* This policy or contract is not protected by the Minnesota Life and Health Insurance Guaranty Association or the Minnesota Insurance Guaranty Association. In the case of insolvency, payment of claims is not guaranteed. Only the assets of this insurer will be available to pay your claim.

Missouri – Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death benefits, if any, under this policy where the policy is issued to a Missouri citizen, unless the insurer can show that the insured intended suicide when s/he applied for the policy, regardless of any language to the contrary in the policy.

New Jersey – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

Tennessee – “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

Texas – “Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.”

Virginia – “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

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