

SERFF Tracking Number: FNWW-126041669 State: Arkansas  
Filing Company: Farmers New World Life Insurance Company State Tracking Number: 41677  
Company Tracking Number: FESWL-APP FOR BENEFITS  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: FESWL Questionnaire  
Project Name/Number: /

## Filing at a Glance

Company: Farmers New World Life Insurance Company

Product Name: FESWL Questionnaire SERFF Tr Num: FNWW-126041669 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num: 41677

Sub-TOI: L08.000 Life - Other Co Tr Num: FESWL-APP FOR BENEFITS State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird  
Disposition Date: 03/02/2009  
Authors: Christine Andreason, Peter Lindstrom  
Date Submitted: 02/27/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 03/02/2009 Explanation for Other Group Market Type:  
State Status Changed: 03/02/2009  
Deemer Date: Created By: Christine Andreason  
Submitted By: Christine Andreason Corresponding Filing Tracking Number:  
Filing Description:

This is a questionnaire to be used when an applicant requests to add a benefit within 90 days of issue of a policy. This questionnaire asks the same questions that would be used on the original application, had the benefit or rider been requested at that time. The questions are the same as on the application which was filed and approved on 11-17-2008, FNWW-125728496. This questionnaire will be added to the policy.

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## Company and Contact

### Filing Contact Information

Christine Andreason, Contract Specialist christine\_andreason@farmersinsurance.com  
 3003 77th Ave SE 206-275-8084 [Phone]  
 Mercer Island, WA 98040 206-236-6526 [FAX]

### Filing Company Information

Farmers New World Life Insurance Company CoCode: 63177 State of Domicile: Washington  
 3003 77th Avenue S.E. Group Code: 212 Company Type: Life  
 Mercer Island, WA 98040 Group Name: State ID Number:  
 (206) 275-8131 ext. [Phone] FEIN Number: 91-0335750

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: 1 form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Farmers New World Life Insurance Company	\$20.00	02/27/2009	26015064

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/02/2009	03/02/2009

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## Disposition

Disposition Date: 03/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Request to Add Benefits/Riders Questionnaire		Yes

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## Form Schedule

**Lead Form Number: 51-1494**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	51-1494	Application/ Request to Add Enrollment Benefits/Riders Form Questionnaire	Initial		65.300	51-1494.pdf

# Farmers New World Life Insurance Company

*Mercer Island Life Office: 3003 77<sup>th</sup> Ave. S.E., Mercer Island, WA 98040-2890 (206) 232-8400*  
*Columbus Life Office: P.O. Box 182325, Columbus, OH 43218-2325 (614) 764-9975*



**FARMERS**  
LIFE INSURANCE

## Simple Term & Farmers EssentialLife® Simple Whole Life

### Request to Add Benefits/Riders Questionnaire

Insured/Proposed Insured \_\_\_\_\_

Application/Policy Number \_\_\_\_\_

#### A. Add Benefits and Riders (This form can be used to add benefits or riders within 90 days of issue only)

<input type="checkbox"/> Accidental Death Benefit \$ _____ <i>(Complete Section B)</i>	Issue Age: 1-60 Benefit Amount: \$10,000-\$300,000 <i>(all companies combined)</i>
<input type="checkbox"/> Waiver of Premium <i>(Complete Section B)</i>	Issue Age: 21-55
Farmers EssentialLife® Simple Whole Life Only:	
<input type="checkbox"/> Owner Waiver of Premium <i>(Complete Section C)</i>	Issue Age of Insured: 0-20 Issue Age of Owner: 21-55
<input type="checkbox"/> Children's Insurance Rider _____ Units <i>(1 Unit = \$1,000) (Complete Section D)</i>	Issue Age of Insured: 21-55 Issue Age of Child: 0-19 Benefit Amount 2-25 units <i>(all companies combined)</i>
<input type="checkbox"/> Guaranteed Insurability Benefit \$ _____ <i>(Complete Section E)</i>	Issue Age of Insured: 0-15 Benefit Amount: \$10,000-\$25,000

#### B. Accidental Death Benefit/Waiver of Premium Information

Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities?  Yes  No

*If "Yes," please check all causes of disability that apply:*

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Motor Vehicle Accident         |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Neck Pain                      |
| <input type="checkbox"/> Back Pain           | <input type="checkbox"/> Paraplegia                     |
| <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Bunionectomy        | <input type="checkbox"/> Pregnancy                      |
| <input type="checkbox"/> Cosmetic Surgery    | <input type="checkbox"/> Rheumatoid Arthritis           |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Dislocated Joints   | <input type="checkbox"/> Tonsillectomy                  |
| <input type="checkbox"/> Hernia Surgery      | <input type="checkbox"/> Other: _____                   |

#### C. Owner Waiver of Premium Information

Name of Policy Owner <i>(First/Middle/Last/Suffix i.e. Jr., Sr.)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight
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Relationship to Primary Insured	Social Security Number (SSN)
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Have you, the Policy Owner/Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having, appendicitis, any kind of cancer or tumor, diabetes, drug or alcohol dependency, gastric reflux, hernia, pneumonia, pregnancy, stroke, or disability, including receiving disability income benefits; or have you ever had any disease or disorder of the heart, immune system, kidney, liver, or lungs?  Yes  No

*If "Yes," please check all the apply:*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Gastric Reflux              | <input type="checkbox"/> Liver                       |
| <input type="checkbox"/> treated and resolved                                      | <input type="checkbox"/> Heart                       | <input type="checkbox"/> Lungs                       |
| <input type="checkbox"/> not treated or not resolved                               | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Cancer or Tumor   | <input type="checkbox"/> treated and resolved        | <input type="checkbox"/> treated and resolved        |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> not treated or not resolved | <input type="checkbox"/> not treated or not resolved |
| <input type="checkbox"/> Disability including receiving disability income benefits | <input type="checkbox"/> Immune System               | <input type="checkbox"/> resolved                    |
| <input type="checkbox"/> Drug or Alcohol Dependency                                | <input type="checkbox"/> Kidney                      | <input type="checkbox"/> Pregnancy                   |
|  |  | <input type="checkbox"/> Stroke                      |

(Signature and date required on page 2)

**D. Children's Insurance Rider Information** Complete only for Children's Insurance Rider. List all children to be covered.

Name of Child (First/Middle/Last/Suffix: i.e. Jr., Sr.)	Gender	Relationship to Proposed Insured	Date of Birth	Social Security Number	Height	Weight

Has any child ever had, or been treated or hospitalized for, any appendicitis, asthma, cancer, congenital or birth disorder, diabetes, heart disorder, hernia, leukemia, premature birth, RSV(Respiratory Syncytial Virus), scoliosis, seizures, tonsillectomy, tubes in ears, tumor, or any other disease or disorder (*Indiana and Oregon residents only: during the past 10 years*) (*Wisconsin residents only: excluding HIV or AIDS*)?  Yes  No

*If "Yes," please provide child's name and disease or disorder:*

**E. Guaranteed Insurability Benefit Information**

- Has the Insured/Proposed Insured had any kind of chest pain; heart disorder; diabetes; stroke; tumor, or consulted with or been treated by any healthcare facility, since the date of the application?  Yes  No
- Has the Insured/Proposed Insured had an application for life, accident, or health insurance, or reinstatement of a policy, declined, postponed, cancelled, or issued with a rating?  Yes  No
- Has the Insured/Proposed Insured been convicted of a crime or had a driver's license suspended or revoked since the date of the application? (*for ages 12-15 only*)  Yes  No

**Taxpayer Certification**

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

**If you are unable to truthfully attest to the statements made in the Taxpayer Certification section please initial and date here: \_\_\_\_\_ . An IRS Form W-9 must be completed, signed and submitted with this Questionnaire.**

**Acknowledgement Signatures**

I acknowledge that I have read this completed Questionnaire, or have had it read to me, and agree that all the answers are true and complete to the best of my knowledge and belief. I understand that Farmers New World Life Insurance Company will rely upon this completed Questionnaire to determine my insurability. This Questionnaire will be attached to and made a part of the policy contract, if issued.

I also acknowledge that I have read, or have had read to me, and that I understand the fraud warning and/or other notice listed on Form 31-4226 for my state of residence if any.

\_\_\_\_\_  
 Insured/Proposed Insured Signature  
 (or parent if Insured is a juvenile)

Signed in \_\_\_\_\_ on \_\_\_\_\_  
 State Month, Day, Year

\_\_\_\_\_  
 Policy Owner/Proposed Policy Owner Signature  
 (if other than Primary Insured), and title, if applicable

Signed in \_\_\_\_\_ on \_\_\_\_\_  
 State Month, Day, Year

\_\_\_\_\_  
 Owner's Spouse Signature (where required  
 in community property states when a person other  
 than Policy Owner's spouse is named as Primary  
 Beneficiary)

\_\_\_\_\_  
 Policy Co-Owner Signature  
 and title, if applicable

\_\_\_\_\_  
 Agent/Representative Signature

\_\_\_\_\_  
 Agent/Representative Name (please print or type)

\_\_\_\_\_  
 Month, Day, Year

\_\_\_\_\_  
 Agent/Representative Code Number

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## Supporting Document Schedules

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Readability Certification.pdf

**Item Status:**

**Status  
Date:**

**Bypassed - Item:** Application

**Bypass Reason:** This is not needed for this filing.

**Comments:**

**ARKANSAS**

**READABILITY CERTIFICATE**

The undersigned certifies as follows:

1. The Flesch scores of the enclosed forms are:

<u>Form Number</u>	<u>Form</u>	<u>Flesch Score</u>
51-1494	Request to Add Benefits/Riders Questionnaire	65.3

2. The form complies with the requirements of Arkansas Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

**FARMERS NEW WORLD LIFE INSURANCE COMPANY**



By: \_\_\_\_\_

Ryan R. Larson

Title: Vice President and Chief Actuary

Date: February 27, 2009