

SERFF Tracking Number: FNWW-126271873 State: Arkansas  
Filing Company: Farmers New World Life Insurance Company State Tracking Number: 43277  
Company Tracking Number: 31-4492  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2009 AR Application filing  
Project Name/Number: 2009 AR Application filing/31-4492

## Filing at a Glance

Company: Farmers New World Life Insurance Company

Product Name: 2009 AR Application filing SERFF Tr Num: FNWW-126271873 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num: 43277

Sub-TOI: L08.000 Life - Other Co Tr Num: 31-4492 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird

Authors: Christine Andreason, Disposition Date: 08/21/2009

Peter Lindstrom

Date Submitted: 08/18/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 2009 AR Application filing

Project Number: 31-4492

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/21/2009

Deemer Date:

Submitted By: Peter Lindstrom

Filing Description:

August 18, 2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/21/2009

Created By: Peter Lindstrom

Corresponding Filing Tracking Number: 31-4492

NAIC NO.: 0212-63177

Re: Form No.: 31-4492 Annuity Application

31-4493 Application for Life Insurance Part 1

SERFF Tracking Number: FNWW-126271873 State: Arkansas  
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2009 AR Application filing  
Project Name/Number: 2009 AR Application filing/31-4492  
31-4494 e-Life Insurance Application  
51-1272 Application for Life Insurance-Amendment C

Dear Sir or Madam:

We are submitting copies of the above referenced form for your approval. All forms are in final format with the exception of subtle changes that may occur in font and pagination due to conversion to our mainframe and/or PC based forms systems.

These forms are intended to replace previously filed and approved forms (See attached charts). These forms are intended for use with all our permanent fixed and variable life policies, and permanent and variable annuities. Only a few minor changes have been made to the previously approved forms. I have enclosed a Red-lined version of each form showing the changes made. These changes are list below:

The term Sex has been changed to Gender

Our replacement questions have been revised to be closer to the NAIC Replacement Model Regulation and Arkansas Bulletin 8-2009. If either question is answered "Yes", then the Replacement form are provided to the applicant. The questions are answered by both the applicant and agent.

No other changes have been made to our previously approved forms.

We will be attaching form 31-4226 the Fraud Warnings and Other Notices page to all of these application forms. Form 31-4226 was previously filed in your state with a similar application form.

The above forms or a substantially similar versions was filed in Washington, our state of domicile, and approved. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. We plan to introduce these forms in your state once approval has been received. This product will be marketed by licensed representatives who are appointed with the company and may sell through bank or agency distribution systems. No advertising has yet been developed for use in your state.

In addition to the policy forms, this filing packet contains the required certifications and filing fees, if any. Washington, our state of domicile has no filing fee. To the best of our knowledge, these forms comply with the laws of your state and department. Please provide your approval of these forms. If you have any questions, please call me at 206-275-8131, fax me at 206-236-6526 or email me at peter.lindstrom@farmersinsurance.com.

Sincerely,

Pete Lindstrom  
Contract Specialist

## Company and Contact

### Filing Contact Information

SERFF Tracking Number: FNWW-126271873 State: Arkansas  
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Peter Lindstrom, Contract Specialist peter.lindstrom@farmersinsurance.com  
 3003 77th Ave SE 206-275-8131 [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	

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$80.00  
 Retaliatory? No  
 Fee Explanation: 4 forms x \$20.00 = \$80.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Farmers New World Life Insurance Company	\$80.00	08/18/2009	29930411

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/21/2009	08/21/2009

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	red-lined copy of changed forms	Peter Lindstrom	08/18/2009	08/18/2009

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## Disposition

Disposition Date: 08/21/2009

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
Supporting Document	chart of forms being replaced		Yes
Supporting Document	statement of variability		Yes
Supporting Document	red-lined copy of changed forms		Yes
Form	Annuity Application		Yes
Form	Application for Life Insurance-Part 1		Yes
Form	e-Life Insurance Application		Yes
Form	Application for Life Insurance-Amendment C		Yes

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**Amendment Letter**

Submitted Date: 08/18/2009

**Comments:**

I have updated my filing with red-lined copies of the previously approved forms. No other changes were made to our forms. See general information and letter.

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: red-lined copy of changed forms**

Comment:

31-4494 NAIC e-Life App - General redlined.pdf  
51-1272 NAIC Amend C redlined for General states.pdf  
31-4493 NAIC Life App Part 1 General redlined 11-08.pdf  
31-4492 NAIC Annuity App redlined Gen states.pdf

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## Form Schedule

### Lead Form Number: 31-4492

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	31-4492	Application/ Annuity Application Enrollment Form	Initial		50.140	31-4492 NAIC Annuity App Bracketed for Filing.pdf
	31-4493	Application/ Application for Life Enrollment Insurance-Part 1 Form	Initial		43.900	31-4493 NAIC Life App Part 1 Gen Bracketed 11-08.pdf
	31-4494	Application/ e-Life Insurance Enrollment Application Form	Initial		54.400	31-4494 NAIC e-Life App - General Bracketed.pdf
	51-1272	Application/ Application for Life Enrollment Insurance-Form Amendment C	Initial		54.400	51-1272 NAIC rev Amend C Bracketed for Filing.pdf



## Plan Descriptions

**Non-Qualified Annuity** - Contributions are made by an individual, trust, estate or business entity and are not tax-deductible. Interest earned is tax-deferred until: (1) an assignment; (2) the annuity is owned by a "non-natural" person (e.g. a trust); or (3) a distribution is made. Upon assignment, withdrawal or distribution, only earnings (interest credited/gain) are included in taxable income. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Traditional Individual Retirement Annuity (IRA)** - Contributions are made by an individual, and may be **tax-deductible** depending on income and whether the IRA owner is covered by an employer-sponsored retirement plan. Interest is tax-deferred until the time of distribution. At distribution, 100% of funds withdrawn may be subject to taxation. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty. **Deposits made between January 1st and April 15th of each year must identify the tax year to which it is to be applied.**

**Savings Incentive Match Plan for Employees (SIMPLE) IRA** - Contributions are funded using employee salary reduction contributions; and either employer matching or non-elective contributions. Contributions are not included in the employee's gross income, and are tax-deductible by the employer. Annuity is owned by the employee. Interest is tax-deferred until the time of distribution. At distribution, 100% of withdrawal is taxable. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Simplified Employee Pension (SEP) IRA** - Contributions are made by the employer, employee, or both. If an employer contribution is to be made for any plan year, it must be made for every eligible employee. Employer contributions are not included in employee's gross income. The employee may also make additional contributions to the SEP IRA (or to a separate IRA) subject to traditional IRA rules. Annuity is owned by the employee. Interest is tax-deferred until the time of distribution. At distribution, 100% of withdrawal may be subject to taxation. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty. **All deposits must be identified as to whether they are employer contributions, or the employee's personal (traditional) IRA contribution. Employee's personal (traditional) IRA contributions made between January 1st and April 15th of each year must identify the tax year to which it is to be applied.**

**Roth IRA** - Contributions are made by an individual, and are not tax-deductible. Interest is tax-deferred until the time of distribution. At time of distribution, the annuity owner will not be taxed on the principal. Earnings (interest credited/gain) may or may not be taxed, depending on the circumstances. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Tax-Sheltered Annuity (TSA)** - Contributions are made by the employer, and not included in the employee's gross income. Tax-sheltered annuities are for employees of tax-exempt educational organizations, religious organizations, and charitable organizations. Annuity is owned by the employee. Interest is tax-deferred until the time of distribution. At distribution, 100% of withdrawal is taxable. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Qualified Pension Plans** - Contributions are made by the employer directly to FNWL, or to a Pension Trust account. Contributions are tax-deductible by the employer and not included in the employee's gross income. Interest is tax-deferred until the time of distribution. Distributions to the employee prior to age 59½ may be subject to IRS 10% premature distribution penalty. Plans must be non-discriminatory, i.e.; they must provide participation for all eligible employees. FNWL's Qualified Pension Plan does not include SEP IRAs or TSAs; nor can it be a profit-sharing plan. The owner should consult with a tax adviser to determine which, if any, Adoption Agreement (Profit Sharing or Money Purchase) will coincide with the Prototype Defined Contribution Plan packet.

**1035-Exchange** - An in kind exchange for certain insurance policies, and non-qualified annuity contracts, as permitted under Section 1035 of the Internal Revenue Code. New policies or contracts can be issued that maintain the original cost basis; and therefore remain tax-deferred.

**Transfer** - Funds are moved, tax-deferred, from one financial institution directly to another. The policy owner does not handle the funds.

**Rollover** - Funds from a traditional IRA, SEP IRA, SIMPLE IRA, or Roth IRA, are distributed to the owner who then must roll the funds over into the same type of account within 60 days of receipt. Funds from a SEP IRA, SIMPLE IRA (after two years of participation in the plan), TSA, or Qualified Pension Plan, are distributed to the owner who then must roll the funds over into a traditional IRA within 60 days of receipt to qualify as a non-taxable rollover. Non-qualified annuities cannot be established with rollover funds.

**Conversion** - Funds are transferred, or rolled over, from a traditional IRA, SEP IRA, or SIMPLE IRA (after two years) to a Roth IRA. In the year of conversion you must pay tax on the distribution, but no IRS 10% premature distribution penalty.

**Recharacterization** - Funds converted to a Roth IRA are moved via a trustee to trustee transfer back to the same type of IRA account that they came from. A regular contribution to a Roth IRA is moved to a traditional IRA (or the reverse). The recharacterization must be completed by your federal income tax return due date (plus extensions) for the tax year of conversion or contribution (or such later date as provided by the IRS).

### Purpose of the Taxpayer Certification

If you certify: 1) on the front side of this application that you are not subject to backup withholding because of underreporting interest and dividends; and 2) if you give the payer the correct Taxpayer Identification Number (TIN), the payer will not be required to withhold 28% of payments made to you.

**Penalties** - If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fine and/or imprisonment.

**Name** - Be sure to enter your correct name. If you are an individual and your name has changed, contact the Social Security Administration to report your new name.

**Privacy Act Notice** - Section 6109 of the Internal Revenue Code requires most recipients of dividend, interest, or other payments to give taxpayer identification numbers to payers who must report the payments to the IRS. IRS uses the numbers for identification purposes. Payers must be given the numbers whether or not recipients are required to file tax returns. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not furnish a taxpayer identification number to a payer. Certain penalties may also apply.

### Agent

Additional forms may be required before an annuity can be issued. Please consult LifeNet, or publications 31-0719 and 31-0798 for further details.

# 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*  
*Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008*



**FARMERS**  
LIFE INSURANCE

Application Number: LA

## Application for Life Insurance Part 1

<b>A. Primary Proposed Insured</b>				
Name of Primary Proposed Insured ( <i>First/Middle/Last/Suffix i.e. Jr., Sr.</i> )				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	Place of Birth ( <i>State, Country</i> )	Social Security Number (SSN)	
Marital Status	Driver License Number	License Issue State	Height	Weight
Residence Address ( <i>Street, City, State, Zip Code</i> )				
Billing Address ( <i>Street, City, State, Zip Code</i> ) ( <i>if different from Residence Address</i> )				
Primary Telephone Number		Secondary Telephone Number		Primary Language Spoken ( <i>if other than English</i> )
Occupation		Duties		Number of Years
Employer Name			Annual Income	Annual Household Income
Parent Name ( <i>if Primary Proposed Insured is a juvenile and if other than Proposed Policy Owner</i> )				
<b>B. Additional Proposed Insured</b>				
Name of Additional Proposed Insured ( <i>First/Middle/Last/Suffix i.e. Jr., Sr.</i> )				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	Place of Birth ( <i>State, Country</i> )	Social Security Number (SSN)	
Marital Status	Driver License Number	License Issue State	Height	Weight
Residence Address ( <i>Street, City, State, Zip Code</i> )				
Occupation		Duties		Number of Years
Employer Name		Relationship to Primary Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____		
<b>C. Proposed Policy Owner</b> Complete only if other than the Primary Proposed Insured. <i>Note: Complete section C for Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional).</i>				
Name of Proposed Policy Owner ( <i>First/Middle/Last/Suffix i.e. Jr., Sr.</i> )				
Primary Telephone Number		Secondary Telephone Number		Primary Language Spoken ( <i>if other than English</i> )
Relationship to Primary Proposed Insured <input type="checkbox"/> Business <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	Place of Birth ( <i>State, Country</i> )	Taxpayer ID Number or SSN	
Address ( <i>Street, City, State, Zip Code</i> )				

**D. Product Information** Plans, Benefits, and Riders may not be available in all states. Benefits and Riders may not be available for all plans.  
 (See Product Guide for Product Information)

Plan _____ Face Amount \$ _____ <input type="checkbox"/> Standard <input type="checkbox"/> Preferred <input type="checkbox"/> Premier <input type="checkbox"/> Non-nicotine <input type="checkbox"/> Nicotine <input type="checkbox"/> Juvenile Accidental Death Benefit \$ _____ { Guaranteed Insurability Benefit } { \$ _____ (juvenile policy only) } <input type="checkbox"/> Waiver of Premium (adult policy only) <input type="checkbox"/> Payor/Owner Benefits (juvenile policy only) <input type="checkbox"/> Other/Additional Insured Insurance Amount \$ _____ Children's Insurance Rider _____ units <input type="checkbox"/> Accelerated Benefit Rider for Terminal Illness (Complete disclosure form, if applicable)	Whole Life plans only - nonforfeiture options: <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-Up Insurance  Premier Whole Life only: Excess Credit Option <input type="checkbox"/> Cash <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Premium/Retirement Deposit Fund <input type="checkbox"/> Reduced Premium Single Premium Rider \$ _____ One-Year Term Rider \$ _____	Universal Life plans only: Death Benefit Option (choose one) <input type="checkbox"/> Increasing/Variable (A) <input type="checkbox"/> Level (B) <input type="checkbox"/> Automatic Increase Benefit (select no more than one of the following) <input type="checkbox"/> Waiver of Deduction <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month { Level Term 2000 (20 and 30 year) only: } <input type="checkbox"/> Critical Illness Accelerated Benefit Rider \$ _____ Benefit Amount (Complete disclosure form and Application Supplement)
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**E. Sales Illustration**

Has the Proposed Policy Owner been provided a written illustration that conforms to this Application for life insurance coverage?  
 Yes  No

**F. Payment and Billing Information** A modal billing fee may apply for payments other than annual.

Total payment submitted with application: \$ \_\_\_\_\_

**Billing Method:**

<input type="checkbox"/> Bank Check Plan <i>monthly deduction</i> (Complete a Bank Authorization form)	<input type="checkbox"/> Farmers EasyPay number _____	<input type="checkbox"/> Direct Bill (select desired frequency)
<input type="checkbox"/> Government Allotment	<input type="checkbox"/> Folio/Agent Payroll Deduction	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
<input type="checkbox"/> Other _____	<input type="checkbox"/> FIG/Farmers Employee Deduction	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly

**Universal Life Plans:** Planned Premium \$ \_\_\_\_\_ Lump Sum Payment \$ \_\_\_\_\_

**Premium/Retirement Deposit Fund:** Initial Payment \$ \_\_\_\_\_ Regular Payment \$ \_\_\_\_\_

<b>G. Other Insurance In Force and Replacement</b> Complete for all Proposed Insured(s). (Use "Other Remarks" in section P if necessary.)	Primary Proposed Insured	Additional Proposed Insured
Is there any life insurance or annuity in-force or application pending on the life of any Proposed Insured? If "Yes," complete required replacement form(s) and provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will any life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance applied for is issued? If "Yes," complete required replacement form(s) and provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Proposed Insured	Company Name	Life Amount	ADB Amount	Policy Number	Will Policy be Replaced?

Is the insurance applied for intended to be a 1035 Exchange? If "Yes," complete 1035 Exchange forms.  Yes  No

**H. Children's Insurance Rider Information** Complete only when Children's Insurance Rider is requested. (Use "Other Remarks" in section P, if necessary.)

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

Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, or any other disease or disorder (**Oregon residents only**: during the past 10 years)?  Yes  No

**If "Yes," provide child's name, disease or disorder, date of diagnosis, tests and medications prescribed. Include Physician, Health Care Provider and/or Hospital name, address, telephone number, and date of last visit:**

**I. Juvenile Plan Information** Complete for juvenile plan only. (Use "Other Remarks" in section P, if necessary.)

List amount of life insurance on:

Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Each Child: \_\_\_\_\_

If there is no insurance on one or both parents, or different amounts on other children, please explain and provide complete details:

**J. Payor/Owner Benefit Information** Complete only when Proposed Policy Owner is applying for Payor/Owner Benefits on a juvenile plan.

Proposed Policy Owner's Height: \_\_\_\_\_ Proposed Policy Owner's Weight: \_\_\_\_\_

Have you, the Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having any kind of cancer or tumor, stroke, diabetes, drug or alcohol dependency; or any disease or disorder of the heart, lungs, liver, or kidney; or disability, including receiving disability income benefits?  Yes  No

**If "Yes," include dates and disorders:**

**K. Proposed Insured(s) Primary Care Physician / Health Care Provider** (Use "Other Remarks" in section P, if necessary.)

Please provide name, address, and telephone number of the Primary Care Physician or Health Care Provider for all Proposed Insureds.

Proposed Insured Name:	Physician/Provider Name and Address:	Date and reason for last visit:

**L. Temporary Insurance Eligibility Question**

In the past two years, has the Primary Proposed Insured, or Additional Proposed Insured named in this Application, 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?  Yes  No

M. Supplementary Information <i>(Use appropriate "Additional Details" space in section P, if necessary.)</i>	Primary Proposed Insured	Additional Proposed Insured
1.a. Are you a United States Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.b. How long have you continuously resided in the United States?		
1.c. If not a United States Citizen, are you residing here legally with a Temporary (Non-immigrant) Visa or Permanent Resident Visa (Green Card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.d. Visa Type and Expiry date:		
2. Have you, in the past 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
3. Have you, in the past 10 years, had your driver's license suspended, revoked, or been convicted of reckless driving, or driving under the influence (DUI/DWI)? <i>If "Yes," provide date(s), type(s) of violation(s), and location (city and state):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past 10 years, pled guilty or no contest to, or been convicted of a felony? <i>If "Yes," provide date(s) of conviction(s), type(s) of felony(ies), location (city and state), and date(s) of release from court supervision:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you, in the past two years, flown as a student pilot, pilot or crewmember (or do you plan to in the future)? <i>If "Yes," complete an aviation questionnaire.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you, in the past two years, on a professional or amateur basis, participated in airborne sports, motor powered racing, mountain or rock climbing, or scuba diving (or do you plan to 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
7. Within the next two years, do you plan to travel or work outside the United States? <i>If "Yes," provide destination, purpose, dates, and length of time:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you had an application for life, accident, or health insurance, or reinstatement of a policy, declined, postponed, cancelled, or issued other than as 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

**N. Beneficiary Information** Beneficiaries by class will share and share alike unless specific percentages are noted. (Use "Other Remarks" in section P, if necessary.)

Primary Beneficiary(ies) Name(s) (First/Middle/Last/Suffix i.e. Jr., Sr.)	% of share (must total 100%)	Date of Birth (mm/dd/yyyy)	Relationship to Primary Proposed Insured
Contingent Beneficiary(ies) Name(s) (First/Middle/Last/Suffix i.e. Jr., Sr.)	% of share (must total 100%)	Date of Birth (mm/dd/yyyy)	Relationship to Primary Proposed Insured

If a Testamentary Trust is named as Beneficiary, has a will been established?  Yes  No  
 Include delay clause?  Yes  No If "Yes,"  15-day, or indicate number of days: \_\_\_\_\_ - days (not to exceed 180 days)

**O. Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional)**

Trust Ownership Name of Trust: \_\_\_\_\_ Trust Date: \_\_\_\_\_  
 Policy Co-Owner  
 Successor Policy Owner  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Primary Proposed Insured: \_\_\_\_\_  
 Social Security/Tax Identification Number: \_\_\_\_\_

**P. Additional Details / Other Remarks**

**Primary Proposed Insured's Additional Details** (Use for any explanation where space is insufficient. Indicate question number.)  
Question Number   Details

**Additional Proposed Insured's Additional Details** (Use for any explanation where space is insufficient. Indicate question number.)  
Question Number   Details

**Other Remarks** (Use for explanation where space is insufficient. Indicate section and give full details.)  
Section   Details

**Certification, Authorization and Acknowledgement Signatures**

**Temporary Insurance Agreement (TIA) Coverage**

Farmers New World Life Insurance Company (FNWL) agrees to provide Temporary Insurance coverage on the life of the Primary Proposed Insured and Additional Proposed Insured named in this Application and children to be covered under a Children's Insurance Rider for the policy face amount applied for (not including riders or supplemental benefits) or \$50,000, whichever is less, subject to the terms, eligibility requirements, and limitations stated on page 7 of this Application. Coverage is not available to any person named in this Application or Application Supplement if: **1.** The Temporary Insurance Eligibility Question in section "L" on page 3 is answered "**Yes**" or left blank by or for the Primary Proposed Insured and Additional Proposed Insured; or **2.** the Temporary Insurance eligibility requirements listed on page 7 **cannot** be met for any Proposed Insured; or **3.** the first full modal premium has **not** been received with this Application. I (We) represent that the answer to the Temporary Insurance Eligibility Question is true to the best of my (our) knowledge and belief. I (We) understand and agree that if the answer is found to be false, the Temporary Insurance may be denied or declined. I (We) acknowledge that I (we) have read, or have had read to me (us), the terms of the Temporary Insurance Agreement and, if the conditions have been truthfully met, I (we) have received a copy of the Receipt of Premium for Temporary Insurance Coverage and the Temporary Insurance Agreement that outlines the terms and conditions of coverage. I (We) understand that no agent or representative is authorized to change or waive the terms of this Temporary Insurance Agreement.

**Illustration**

If the Proposed Policy Owner(s) has not been provided a written illustration, I (we), as Proposed Policy Owner(s), acknowledge that no illustration conforming to the coverage being requested has been provided yet, and if required by state regulation, an illustration conforming to the policy as issued will be provided no later than at the time of the Policy Contract delivery.

**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 any of the answers above are "No," please initial and date here: \_\_\_\_\_ . An IRS Form W-9 must be completed, signed and submitted 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 FNWL, its reinsurers and their authorized representatives any such information. 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 my (our) state laws address the collection, use, and disclosure of HIV/Acquired Immunodeficiency Syndrome (AIDS) related information by Insurers, I (we) will receive a separate notice regarding the collection and disclosure of HIV/AIDS related information. I (We) understand that portions or all of the data collected to create this Application for Life Insurance Part 1 (Application), including my (our) signature(s), may be transmitted by electronic means 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 this Application with the Policy Contract, if issued, or upon receipt of a written request directed to FNWL.

**Acknowledgement**

I (We) have read, or have had read to me (us), the Important Notice disclosure statement given to me (us) on this date. I (We) have read the completed Application, or have had it read to me (us), and agree that all answers are true and complete to the best of my (our) knowledge and belief and will be relied upon to determine my (our) insurability. I (We) acknowledge that this Application and any additional applications, application amendments, application supplements, questionnaires, and medical examination forms, completed and signed by me (us), are part of the Application and will be attached to, and made part of the Policy Contract, if issued. I (We) understand that receipt of the Application and any attached forms by FNWL does not guarantee a policy will be issued. **I (We) agree that: (1) I (We) will notify FNWL if any statement or answer given in any part of the Application changes prior to delivery of the Policy Contract; and (2) except as provided in the Temporary Insurance Agreement, if eligible, the insurance policy will not begin unless the first modal premium is paid and all persons proposed for insurance are living and insurable as set forth in applications attached to the Policy Contract when it is delivered to the Policy Owner on or after the issue date.** I (We) also acknowledge that I (we) have read, or have had read to me (us), the fraud warning and/or other notice listed on Form 31-4226 for my (our) state of residence, if any.

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

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

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

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

\_\_\_\_\_  
**Additional Proposed Insured Signature**

\_\_\_\_\_  
**Proposed 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

I certify that I have truly and accurately recorded on this Application the information given by the Primary Proposed Insured, Additional Proposed Insured, and Proposed Policy Owner(s). To the best of my knowledge, there  **Is**  **Is Not** any life insurance or annuity in-force or application pending on the life of the Proposed Insured. To the best of my knowledge, the life insurance applied for  **Is**  **Is Not** intended to replace or reduce current coverage with this or any other company. If a replacement, was sales material used in the solicitation?  **Yes**  **No**. If "Yes," you must submit copies of the materials to FNWL and/or the Proposed Policy Owner(s), if applicable, as required by state regulations.

\_\_\_\_\_  
**Agent Name** (please print or type)

\_\_\_\_\_  
**Agent Signature**

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

\_\_\_\_\_  
**Date**

# 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  
Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008



**FARMERS**  
LIFE INSURANCE

Receipt Number: LA

## Receipt of Premium for Temporary Insurance Coverage

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_  
in connection with the Application for Life Insurance Part 1 bearing the same number as this receipt. If the Company declines to issue a policy, this payment will be refunded without interest. Please make check payable to Farmers New World Life.

Dated \_\_\_\_\_ Signature of Agent or Authorized Representative X \_\_\_\_\_

## Farmers New World Life Insurance Company

### Temporary Insurance Agreement for Application for Life Insurance

In consideration of the Application and payment of the modal premium, Farmers New World Life Insurance Company (FNWL) agrees to provide life insurance for a limited period of time, subject to the following conditions and limitations:

Temporary Insurance coverage applies only to the Primary Proposed Insured, and Additional Proposed Insured named in this Application, and children to be covered under a Children's Insurance Rider, and is limited to \$50,000 or the amount applied for (excluding any riders and supplemental benefits), whichever is less; and is subject to the terms, eligibility requirements and limitations stated below. Temporary Insurance coverage does not include any benefits provided under riders or supplemental benefits applied for or made a part of the policy.

#### No coverage is in effect unless the following eligibility requirements are met:

1. The Primary Proposed Insured, Additional Proposed Insured, and children to be covered under a Children's Insurance Rider, are more than 15 days and less than 70 years of age on the date this Application is signed; and
2. the Temporary Insurance Eligibility Question is truthfully answered "No" for the Primary Proposed Insured and Additional Proposed Insured named in this Application.

**Important: If these two requirements are not met, no agent or representative of FNWL is authorized to accept money and no coverage is in effect. No agent or representative has the authority to change the terms and conditions of this Agreement.**

#### Temporary Insurance coverage begins on the date:

1. The two eligibility requirements above are met; and
2. the Primary Proposed Insured, Additional Proposed Insured, and Proposed Policy Owner(s) completes and signs this Application; and
3. the selected modal premium (in no case less than 1/12<sup>th</sup> of the minimum first year's premium) is submitted to FNWL.

#### Temporary Insurance coverage ends on the date:

1. The life insurance policy takes effect; or
2. the Proposed Policy Owner receives notice that either this Temporary Insurance coverage or the Application for Life Insurance has been declined; and in no case later than 12:01 a.m. Pacific Standard Time of the fifth day after FNWL has mailed a letter giving such notice; or
3. FNWL receives the Proposed Policy Owner's signed request to cancel; in which case the full amount paid will be refunded.

#### No temporary benefits will be paid if:

1. The initial premium check and/or draft submitted is not honored by the bank upon first presentation; or
2. the Primary Proposed Insured, Additional Proposed Insured, or any child to be covered under the Children's Insurance Rider, dies by suicide whether sane or insane; in which case FNWL's only obligation will be to refund the premium submitted; or
3. a material misrepresentation or omission of fact is made with respect to the eligibility requirements or the Temporary Insurance Eligibility Question; in which case Temporary Insurance coverage will be void and FNWL's only obligation shall be to return the premium paid.

Any Temporary Insurance coverage payable shall be paid to the Beneficiary(ies) listed in this Application or Children's Insurance Rider, whichever is applicable.

# 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*

*Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008*



**FARMERS**  
LIFE INSURANCE

## Important Notice

### Leave this Disclosure Statement with the Primary Proposed Insured and Additional Proposed Insured

We appreciate your Application for Life Insurance 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. You have the right to be interviewed in connection with this report. 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. 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 the 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 or its reinsurers, may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization to 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 {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com.}

Farmers New World Life, 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.

# Farmers New World Life Insurance Company

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**FARMERS**  
LIFE INSURANCE

Application Policy Number: **EA**

## e-Life Insurance Application

<b>A. Primary Proposed Insured</b>			
Name of Primary Proposed Insured _____			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Place of Birth _____	Social Security Number (SSN) _____
Driver License Number _____		License Issue State _____	
Residence Address _____			
Billing Address _____			
Primary Telephone Number _____	Secondary Telephone Number _____	Primary Language Spoken <i>(if other than English)</i> _____	
Parent Name <i>(If a juvenile policy)</i> _____			
<b>B. Proposed Policy Owner</b> Completed only when other than Primary Proposed Insured. <i>(Trust Ownership, Policy Co-Owner and Successor Policy Owner information is in section I).</i>			
Name of Proposed Policy Owner _____			
Primary Telephone Number _____	Secondary Telephone Number _____	Primary Language Spoken <i>(if other than English)</i> _____	
Relationship to Primary Proposed Insured <input type="checkbox"/> Business <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Place of Birth _____	Taxpayer ID Number or SSN _____
Address _____			
<b>C. Product Information</b> Plans, Benefits, and Riders may not be available in all states. Benefits and Riders may not be available for all plans. <i>(See Product Guide for Product Information)</i>			
Plan _____ Face Amount \$ _____ <input type="checkbox"/> Standard <input type="checkbox"/> Preferred <input type="checkbox"/> Premier <input type="checkbox"/> Non-nicotine <input type="checkbox"/> Nicotine <input type="checkbox"/> Juvenile Accidental Death Benefit \$ _____ { Guaranteed Insurability Benefit } \$ _____ <i>(juvenile policy only)</i> <input type="checkbox"/> Waiver of Premium <i>(adult policy only)</i> <input type="checkbox"/> Payor/Owner Benefits <i>(juvenile policy only)</i> Children's Insurance Rider _____ units <input type="checkbox"/> Accelerated Benefit Rider for Terminal Illness	<i>Whole Life plans only - nonforfeiture options:</i> <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-Up Insurance { <i>Premier Whole Life only:</i> Excess Credit Option <input type="checkbox"/> Cash <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Premium/Retirement Deposit Fund <input type="checkbox"/> Reduced Premium Single Premium Rider \$ _____ One-Year Term Rider \$ _____         }	<i>Universal Life plans only:</i> Death Benefit Option <i>(choose one)</i> <input type="checkbox"/> Increasing/Variable (A) <input type="checkbox"/> Level (B) <input type="checkbox"/> Automatic Increase Benefit <i>(select no more than one of the following)</i> <input type="checkbox"/> Waiver of Deduction <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month { <i>Level Term 2000 (20 and 30 year) only:</i> <input type="checkbox"/> Critical Illness Accelerated Benefit Rider \$ _____ Benefit Amount         }	
<b>D. Sales Illustration</b>			
Has the Proposed Policy Owner been provided a written illustration that conforms to this Application for life insurance coverage? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			

**E. Payment and Billing Information** A modal billing fee may apply for payments other than annual.

Total payment submitted with application: \$ \_\_\_\_\_

**Billing Method:**

- Bank Check Plan                       Farmers EasyPay number \_\_\_\_\_                       Direct Bill  
 Government Allotment                       Folio/Agent Payroll Deduction                       Annual                       Semi-Annual  
 Other \_\_\_\_\_                       FIG/Farmers Employee Deduction                       Monthly                       Quarterly

**Universal Life Plans:**                      Planned Premium \$ \_\_\_\_\_                      Lump Sum Payment \$ \_\_\_\_\_

**Premium/Retirement Deposit Fund:**                      Initial Payment \$ \_\_\_\_\_                      Regular Payment \$ \_\_\_\_\_

**F. Other Insurance In Force and Replacement** Completed for all Proposed Insured(s). *(Overflow of details appears in section J.)*

Is there any life insurance or annuity in-force or application pending on the life of any Proposed Insured?                       Yes  No  
*(Details listed below.) (If "Yes," required replacement form(s) provided)*

Will any life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance applied for is issued? *(Details listed below.) (If "Yes," required replacement form(s) provided)*                       Yes  No

Proposed Insured	Company Name	Life Amount	ADB Amount	Policy Number	Will Policy be Replaced?

Is the insurance applied for intended to be a 1035 Exchange? *(If "Yes," required 1035 Exchange forms provided)*                       Yes  No

**G. Temporary Insurance Eligibility Question**

In the past two years, has the Primary Proposed Insured named in this Application, 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?                       Yes  No

**H. Beneficiary Information** Beneficiaries by class will share and share alike unless specific percentages are noted.

Primary Beneficiary(ies) Name(s)	% of share <i>(must total 100%)</i>	Date of Birth	Relationship to Primary Proposed Insured
Contingent Beneficiary(ies) Name(s)	% of share <i>(must total 100%)</i>	Date of Birth	Relationship to Primary Proposed Insured

If a Testamentary Trust is named as Beneficiary, has a will been established?                       Yes  No

Include delay clause?  Yes  No If "Yes,"  15-day, or indicate number of days: \_\_\_\_\_ - days *(not to exceed 180 days)*

**I. Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional)**

- Trust Ownership    Name of Trust: \_\_\_\_\_                      Trust Date: \_\_\_\_\_  
 Policy Co-Owner  
 Successor Policy Owner  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Gender: \_\_\_\_\_    Date of Birth: \_\_\_\_\_                      Relationship to Primary Proposed Insured: \_\_\_\_\_  
 Social Security/Tax Identification Number: \_\_\_\_\_

**J. Additional Details / Other Remarks** *(Details from answers where space is insufficient appear in this section. Overflow of this section appears on an e-Life Application Addendum.)*

Section	Additional Details

**Certification, Authorization and Acknowledgement Signatures**

**Temporary Insurance Agreement (TIA) Coverage**

Farmers New World Life Insurance Company (FNWL) agrees to provide Temporary Insurance coverage on the life of the Primary Proposed Insured named in this Application and children to be covered under a Children's Insurance Rider for the policy face amount applied for (not including riders or supplemental benefits) or \$50,000, whichever is less, subject to the terms, eligibility requirements, and limitations stated on page 4 of this Application. Coverage is not available to any person named in this Application or Application Supplement if: 1. The Temporary Insurance Eligibility Question in section "G" on page 2 is answered "Yes" or left blank by or for the Primary Proposed Insured; or 2. the Temporary Insurance eligibility requirements listed on page 4 cannot be met for any Proposed Insured; or 3. the first full modal premium has not been received with this Application. I, the Primary Proposed Insured, represent that the answer to the Temporary Insurance Eligibility Question is true to the best of my knowledge and belief. I (We) understand and agree that if the answer is found to be false, the Temporary Insurance may be denied or declined. I (We) acknowledge that I (we) have read, or have had read to me (us), the terms of the Temporary Insurance Agreement and, if the conditions have been truthfully met, I (we) have received a copy of the Receipt of Premium for Temporary Insurance Coverage and the Temporary Insurance Agreement that outlines the terms and conditions of coverage. I (We) understand that no agent or representative is authorized to change or waive the terms of this Temporary Insurance Agreement.

**Illustration**

If the Proposed Policy Owner(s) has not been provided a written illustration, I (we), as Proposed Policy Owner(s), acknowledge that no illustration conforming to the coverage being requested has been provided yet, and if required by state regulation, an illustration conforming to the policy as issued will be provided no later than at the time of the Policy Contract delivery.

**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 any of the answers above are "No," please initial and date here: \_\_\_\_\_. An IRS Form W-9 must be completed, signed and submitted 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 FNWL, its reinsurers and their authorized representatives any such information. 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 my (our) state laws address the collection, use, and disclosure of HIV/Acquired Immunodeficiency Syndrome (AIDS) related information by Insurers, I (we) will receive a separate notice regarding the collection and disclosure of HIV/AIDS related information. I (We) understand that portions or all of the data collected to create this e-Life Insurance Application (Application), including my (our) signature(s), may be transmitted by electronic means 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 this Application with the Policy Contract, if issued, or upon receipt of a written request directed to FNWL.

**Acknowledgement**

I, the Primary Proposed Insured, have read, or have had read to me, the Important Notice disclosure statement given to me on this date. I (We) have read the completed Application, or have had it read to me (us), and agree that all answers are true and complete to the best of my (our) knowledge and belief and will be relied upon to determine my (our) insurability. I (We) acknowledge that this Application and any additional applications, application amendments, application supplements, questionnaires, and medical examination forms, completed and signed by me (us), are part of the Application and will be attached to, and made part of the Policy Contract, if issued. I (We) understand that receipt of the Application and any attached forms by FNWL does not guarantee a policy will be issued. I (We) agree that: (1) I (We) will notify FNWL if any statement or answer given in any part of the Application changes prior to delivery of the Policy Contract; and (2) except as provided in the Temporary Insurance Agreement, if eligible, the insurance policy will not begin unless the first modal premium is paid and all persons proposed for insurance are living and insurable as set forth in applications attached to the Policy Contract when it is delivered to the Policy Owner on or after the issue date. I (We) also acknowledge that I (we) have read, or have had read to me (us), the fraud warning and/or other notice listed on Form 31-4226 for my (our) state of residence, if any.

\_\_\_\_\_  
Signed at \_\_\_\_\_ on \_\_\_\_\_  
Primary Proposed Insured Signature (or parent if Primary Proposed Insured is a juvenile) State Month, Day, Year

\_\_\_\_\_  
Signed at \_\_\_\_\_ on \_\_\_\_\_  
Proposed Policy Owner Signature (if other than Primary Proposed Insured), and title, if applicable State Month, Day, Year

\_\_\_\_\_  
Proposed 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

I certify that I have truly and accurately recorded on this Application the information given by the Primary Proposed Insured, and Proposed Policy Owner(s). To the best of my knowledge, there Is Is Not any life insurance or annuity in-force or application pending on the life of the Proposed Insured. To the best of my knowledge, the life insurance applied for Is Is Not intended to replace or reduce current coverage with this or any other company. If a replacement, was sales material used in the solicitation? Yes No. Copies of the materials must be submitted to FNWL and/or the Proposed Policy Owner(s), if applicable, as required by state regulations.

\_\_\_\_\_  
Agent Signature

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

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

\_\_\_\_\_  
Date

# 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  
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Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008 }



**FARMERS**  
LIFE INSURANCE

Receipt Number: EA

## *Receipt of Premium for Temporary Insurance Coverage*

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_  
in connection with the e-Life Insurance Application bearing the same number as this receipt. If the Company declines to issue a policy, this payment will be refunded without interest. Please make check payable to Farmers New World Life.

Dated \_\_\_\_\_ Signature of Agent or Authorized Representative X \_\_\_\_\_

## Farmers New World Life Insurance Company

### Temporary Insurance Agreement for Application for Life Insurance

In consideration of the Application and payment of the modal premium, Farmers New World Life Insurance Company (FNWL) agrees to provide life insurance for a limited period of time, subject to the following conditions and limitations:

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#### No coverage is in effect unless the following eligibility requirements are met:

1. The Primary Proposed Insured, and children to be covered under a Children's Insurance Rider, are more than 15 days and less than 70 years of age on the date this Application is signed; and
2. the Temporary Insurance Eligibility Question is truthfully answered "No" for the Primary Proposed Insured named in this Application.

**Important: If these two requirements are not met, no agent or representative of FNWL is authorized to accept money and no coverage is in effect. No agent or representative has the authority to change the terms and conditions of this Agreement.**

#### Temporary Insurance coverage begins on the date:

1. The two eligibility requirements above are met; and
2. the Primary Proposed Insured, and Proposed Policy Owner(s) completes and signs this Application; and
3. the selected modal premium (in no case less than 1/12<sup>th</sup> of the minimum first year's premium) is submitted to FNWL.

Any Temporary Insurance coverage payable shall be paid to the Beneficiary(ies) listed in this Application or Children's Insurance Rider, whichever is applicable.

#### Temporary Insurance coverage ends on the date:

1. The life insurance policy takes effect; or
2. the Proposed Policy Owner receives notice that either this Temporary Insurance coverage or the Application for Life Insurance has been declined; and in no case later than 12:01 a.m. Pacific Standard Time of the fifth day after FNWL has mailed a letter giving such notice; or
3. FNWL receives the Proposed Policy Owner's signed request to cancel; in which case the full amount paid will be refunded.

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1. The initial premium check and/or draft submitted is not honored by the bank upon first presentation; or
2. the Primary Proposed Insured, or any child to be covered under the Children's Insurance Rider, dies by suicide whether sane or insane; in which case FNWL's only obligation will be to refund the premium submitted; or
3. a material misrepresentation or omission of fact is made with respect to the eligibility requirements or the Temporary Insurance Eligibility Question; in which case Temporary Insurance coverage will be void and FNWL's only obligation shall be to return the premium paid.

# Farmers New World Life Insurance Company

*Merger Island Life Office: 3003 77<sup>th</sup> Ave. S.E., Mercer Island, WA 98040-2890 (206) 232-8400*  
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*Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008*



**FARMERS**  
LIFE INSURANCE

## Important Notice

### Leave this Disclosure Statement with the Primary Proposed Insured

We appreciate your Application for Life Insurance 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. You have the right to be interviewed in connection with this report. The information is secured by an independent inspection company or by Farmers New World Life through personal interviews with your friends, neighbor, 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. 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 the 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 or its reinsurers, may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization to 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: {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com. }

Farmers New World Life, 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.

# Farmers New World Life Insurance Company

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**FARMERS**  
LIFE INSURANCE

Policy Number: \_\_\_\_\_

## Application for Life Insurance – Amendment C

### A. Proposed Insured

Name of Proposed Insured <i>(Please print: First/Middle/Last/Suffix i.e. Jr., Sr.)</i>		Height	Weight
Occupation	Duties		Number of Years
Employer Name		Annual Income	Annual Household Income

### B. Other Insurance In Force and Replacement *(Use "Additional Details" in section F, if necessary.)*

Is there any life insurance or annuity in-force or application pending on the life of the Proposed Insured?  Yes  No  
*If "Yes," complete required replacement form(s) and provide details below.*

Will any life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance applied for is issued? *If "Yes," complete required replacement form(s) and provide details below.*  Yes  No

Company Name	Life Amount	ADB Amount	Policy Number	Will Policy be Replaced

### C. Children's Insurance Rider Information *(Use "Additional Details" in section F, if necessary.)*

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

Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, or any other disease or disorder (**Oregon residents only:** during the past 10 years)?  Yes  No

*If "Yes," provide child's name, disease or disorder, date of diagnosis, tests and medications prescribed. Include Physician, Health Care Provider and/or Hospital name, address, telephone number, and date of last visit:*

### D. Juvenile Plan Information *(Use "Additional Details" in section F, if necessary.)*

List amount of life insurance on:  
 Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Each Child: \_\_\_\_\_

If there is no insurance on one or both parents, or different amounts on other children, please explain and provide complete details:

**E. Payor/Owner Benefit Information** *(Use "Additional Details" in section F, if necessary.)*

Name of Proposed Policy Owner *(Please print: First/Middle/Last/Suffix i.e. Jr., Sr.)*

Proposed Policy Owner's Height: Proposed Policy Owner's Weight:

Have you, the Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having any kind of cancer or tumor, stroke, diabetes, drug or alcohol dependency; or any disease or disorder of the heart, lungs, liver, or kidney; or disability, including receiving disability income benefits?  Yes  No

**If "Yes," include dates and disorders:**

**F. Additional Details** *(Use a separate sheet signed and dated by the Proposed Insured and/or Proposed Owner, if necessary.)*

**Authorization and Acknowledgement Signatures**

I (We) understand that portions or all of the data collected to create this Application for Life Insurance Amendment C (Amendment C), including my (our) signature(s), may be transmitted by electronic means 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 this Amendment C with the Policy Contract, if issued, or upon receipt of a written request directed to Farmers New World Life Insurance Company.

I (We) have read the completed Amendment C, or have had it read to me (us), and agree that all answers are true and complete to the best of my (our) knowledge and belief and will be relied upon to determine my (our) insurability. I (We) acknowledge that this Amendment C, completed and signed by me (us), is part of the Application and will be attached to, and made part of the Policy Contract, if issued.

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

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

Proposed Policy Owner Signature (if other than Proposed Insured) \_\_\_\_\_ Date \_\_\_\_\_

To the best of my knowledge, there Is Is Not any life insurance or annuity in-force or application pending on the life of the Proposed Insured. To the best of my knowledge, the life insurance applied for Is Is Not intended to replace or reduce current coverage with this or any other company. If a replacement, was sales material used in the solicitation? Yes No. *If "Yes," you must submit copies of the materials to Farmers New World Life Insurance Company and/or the Proposed Policy Owner(s), if applicable, as required by state regulations.*

Agent Name *(please print or type)* \_\_\_\_\_ Agent Signature \_\_\_\_\_

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

SERFF Tracking Number: FNWW-126271873 State: Arkansas  
 Filing Company: Farmers New World Life Insurance Company State Tracking Number: 43277  
 Company Tracking Number: 31-4492  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2009 AR Application filing  
 Project Name/Number: 2009 AR Application filing/31-4492

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> readability Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> Not required for this filing		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> chart of forms being replaced		
<b>Comments:</b>		
<b>Attachment:</b> AR List of forms replaced.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> statement of variability		
<b>Comments:</b>		
<b>Attachment:</b> Farmers Statement of Variability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> red-lined copy of changed forms		
<b>Comments:</b>		
<b>Attachments:</b>		

*SERFF Tracking Number:* FNWW-126271873      *State:* Arkansas  
*Filing Company:* Farmers New World Life Insurance Company      *State Tracking Number:* 43277  
*Company Tracking Number:* 31-4492  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* 2009 AR Application filing  
*Project Name/Number:* 2009 AR Application filing/31-4492

31-4494 NAIC e-Life App - General redlined.pdf  
51-1272 NAIC Amend C redlined for General states.pdf  
31-4493 NAIC Life App Part 1 General redlined 11-08.pdf  
31-4492 NAIC Annuity App redlined Gen states.pdf

## READABILITY CERTIFICATION

Farmers New World Life Insurance Company, NAIC #:0212 Group No. 63177, Co. No., hereby certifies that the following form(s) comply with the requirements and achieve a Flesch reading ease test score of:

FORM NUMBER	FLESCH SCORE
31-4492	50.14
51-1272	54.4
31-4494	54.4
31-4493	43.9



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Signature of Company Officer

Ryan R. Larson, Senior Vice President and Chief Actuary  
Officer Full Name                      Officer Title

Date: August 18, 2009

# Farmers New World Life Insurance

## Life Insurance form replacement list

State	Form Number	Form Description	Status	Notes
AR	31-4492	Annuity Applications	Pending	replaces 31-0862
AR	31-4493	Application for Life Insurance - Part 1	Pending	replaces 31-4410
AR	31-4494	e-life Insurance Application	Pending	replaces 31-4425
AR	51-1272	Application for Life Insurance-Amendment C	pending	replaces 51-1260

FARMERS NEW WORLD LIFE INSURANCE COMPANY  
3003 77<sup>th</sup> Avenue SE, Mercer island, WA 98040-0290

EXPLANATION OF VARIABILITY  
Application Forms

Brackets denote that the text within the brackets is variable subject to the following limitations on each of the applications in this filing:

- Address and Phone Number- Will insert the company home office address and phone number for sections listed on each application.
- Administrative office address and telephone number- Will insert the company administrative office address and telephone number for sections listed on each application.
- Fraud Warning and Other Notices:
  - Specific fraud statements may be revised based upon revised state law and regulation regarding such statements. Additional state fraud statements may be added upon newly enacted statute or newly adopted regulation in a given state that requires such on our application form.
- Taxpayer Certification- This section is bracketed for changes required by the IRS in the event that their language is revised.
- Important Notice- Will insert the Medical Insurance Bureau address and telephone number.
- Corporate Logo- The company would like the option, at its discretion, to change the corporate logo without refiling.

**Application for Life Insurance Part 1-** Brackets are provided in the Product Information section for benefits that may be made available or not be offered on future products or where a certain product may no longer be offered due to refiling of new products. We will be refiling and replacing some products due to the 2001 CSO tables.

**E-Life Insurance Application -** Brackets are provided in the Product Information section for benefits that may be made available or not be offered on future products or where a certain product may no longer be offered due to refiling of new products. We will be refiling and replacing some products due to the 2001 CSO tables.

# Farmers New World Life Insurance Company

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**FARMERS**  
LIFE INSURANCE

Application Policy Number: **EA**

## e-Life Insurance Application

<b>A. Primary Proposed Insured</b>			
Name of Primary Proposed Insured _____			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Place of Birth _____	Social Security Number (SSN) _____
Driver License Number _____		License Issue State _____	
Residence Address _____			
Billing Address _____			
Primary Telephone Number _____	Secondary Telephone Number _____	Primary Language Spoken <i>(if other than English)</i> _____	
Parent Name <i>(If a juvenile policy)</i> _____			
<b>B. Proposed Policy Owner</b> Completed only when other than Primary Proposed Insured. <i>(Trust Ownership, Policy Co-Owner and Successor Policy Owner information is in section I).</i>			
Name of Proposed Policy Owner _____			
Primary Telephone Number _____	Secondary Telephone Number _____	Primary Language Spoken <i>(if other than English)</i> _____	
Relationship to Primary Proposed Insured <input type="checkbox"/> Business <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Place of Birth _____	Taxpayer ID Number or SSN _____
Address _____			
<b>C. Product Information</b> Plans, Benefits, and Riders may not be available in all states. Benefits and Riders may not be available for all plans. <i>(See Product Guide for Product Information)</i>			
Plan _____ Face Amount \$ _____ <input type="checkbox"/> Standard <input type="checkbox"/> Preferred <input type="checkbox"/> Premier <input type="checkbox"/> Non-nicotine <input type="checkbox"/> Nicotine <input type="checkbox"/> Juvenile Accidental Death Benefit \$ _____ { Guaranteed Insurability Benefit } \$ _____ <i>(juvenile policy only)</i> <input type="checkbox"/> Waiver of Premium <i>(adult policy only)</i> <input type="checkbox"/> Payor/Owner Benefits <i>(juvenile policy only)</i> Children's Insurance Rider _____ units <input type="checkbox"/> Accelerated Benefit Rider for Terminal Illness	Whole Life plans only - nonforfeiture options: <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-Up Insurance Premier Whole Life only: Excess Credit Option <input type="checkbox"/> Cash <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Premium/Retirement Deposit Fund <input type="checkbox"/> Reduced Premium Single Premium Rider \$ _____ One-Year Term Rider \$ _____	Universal Life plans only: Death Benefit Option <i>(choose one)</i> <input type="checkbox"/> Increasing/Variable (A) <input type="checkbox"/> Level (B) <input type="checkbox"/> Automatic Increase Benefit <i>(select no more than one of the following)</i> <input type="checkbox"/> Waiver of Deduction <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month { Level Term 2000 (20 and 30 year) only: } <input type="checkbox"/> Critical Illness Accelerated Benefit Rider \$ _____ Benefit Amount	
<b>D. Sales Illustration</b>			
Has the Proposed Policy Owner been provided a written illustration that conforms to this Application for life insurance coverage? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			

**E. Payment and Billing Information** A modal billing fee may apply for payments other than annual.

Total payment submitted with application: \$ \_\_\_\_\_

**Billing Method:**

- Bank Check Plan
- Government Allotment
- Other \_\_\_\_\_
- Farmers EasyPay number \_\_\_\_\_
- Folio/Agent Payroll Deduction
- FIG/Farmers Employee Deduction
- Direct Bill
- Annual
- Monthly
- Semi-Annual
- Quarterly

**Universal Life Plans:** Planned Premium \$ \_\_\_\_\_ Lump Sum Payment \$ \_\_\_\_\_

**Premium/Retirement Deposit Fund:** Initial Payment \$ \_\_\_\_\_ Regular Payment \$ \_\_\_\_\_

**F. Other Insurance In Force and Replacement** Completed for all Proposed Insured(s). (Overflow of details appears in section J.)

Is there any life insurance or annuity in-force or application pending on the life of any Proposed Insured?  Yes  No  
(Details listed below.) (If "Yes," required replacement form(s) provided)

Will any life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance applied for is issued? (Details listed below.) (If "Yes," required replacement form(s) provided)  Yes  No

Proposed Insured	Company Name	Life Amount	ADB Amount	Policy Number	Will Policy be Replaced?

Is the insurance applied for intended to be a 1035 Exchange? (If "Yes," required 1035 Exchange forms provided)  Yes  No

**G. Temporary Insurance Eligibility Question**

In the past two years, has the Primary Proposed Insured named in this Application, 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?  Yes  No

**H. Beneficiary Information** Beneficiaries by class will share and share alike unless specific percentages are noted.

Primary Beneficiary(ies) Name(s)	% of share (must total 100%)	Date of Birth	Relationship to Primary Proposed Insured
Contingent Beneficiary(ies) Name(s)	% of share (must total 100%)	Date of Birth	Relationship to Primary Proposed Insured

If a Testamentary Trust is named as Beneficiary, has a will been established?  Yes  No

Include delay clause?  Yes  No If "Yes,"  15-day, or indicate number of days: \_\_\_\_\_ - days (not to exceed 180 days)

**I. Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional)**

- Trust Ownership Name of Trust: \_\_\_\_\_ Trust Date: \_\_\_\_\_
- Policy Co-Owner
- Successor Policy Owner  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Primary Proposed Insured: \_\_\_\_\_  
Social Security/Tax Identification Number: \_\_\_\_\_

**J. Additional Details / Other Remarks** (Details from answers where space is insufficient appear in this section. Overflow of this section appears on an e-Life Application Addendum.)

Section	Additional Details

**Certification, Authorization and Acknowledgement Signatures**

**Temporary Insurance Agreement (TIA) Coverage**

Farmers New World Life Insurance Company (FNWL) agrees to provide Temporary Insurance coverage on the life of the Primary Proposed Insured named in this Application and children to be covered under a Children's Insurance Rider for the policy face amount applied for (not including riders or supplemental benefits) or \$50,000, whichever is less, subject to the terms, eligibility requirements, and limitations stated on page 4 of this Application. Coverage is not available to any person named in this Application or Application Supplement if: **1.** The Temporary Insurance Eligibility Question in section "G" on page 2 is answered "**Yes**" or left blank by or for the Primary Proposed Insured; or **2.** the Temporary Insurance eligibility requirements listed on page 4 **cannot** be met for any Proposed Insured; or **3.** the first full modal premium has **not** been received with this Application. I, the Primary Proposed Insured, represent that the answer to the Temporary Insurance Eligibility Question is true to the best of my knowledge and belief. I (We) understand and agree that if the answer is found to be false, the Temporary Insurance may be denied or declined. I (We) acknowledge that I (we) have read, or have had read to me (us), the terms of the Temporary Insurance Agreement and, if the conditions have been truthfully met, I (we) have received a copy of the Receipt of Premium for Temporary Insurance Coverage and the Temporary Insurance Agreement that outlines the terms and conditions of coverage. I (We) understand that no agent or representative is authorized to change or waive the terms of this Temporary Insurance Agreement.

**Illustration**

If the Proposed Policy Owner(s) has not been provided a written illustration, I (we), as Proposed Policy Owner(s), acknowledge that no illustration conforming to the coverage being requested has been provided yet, and if required by state regulation, an illustration conforming to the policy as issued will be provided no later than at the time of the Policy Contract delivery.

**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 any of the answers above are "No," please initial and date here: \_\_\_\_\_ . An IRS Form W-9 must be completed, signed and submitted 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 FNWL, its reinsurers and their authorized representatives any such information. 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 my (our) state laws address the collection, use, and disclosure of HIV/Acquired Immunodeficiency Syndrome (AIDS) related information by Insurers, I (we) will receive a separate notice regarding the collection and disclosure of HIV/AIDS related information. I (We) understand that portions or all of the data collected to create this e-Life Insurance Application (Application), including my (our) signature(s), may be transmitted by electronic means 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 this Application with the Policy Contract, if issued, or upon receipt of a written request directed to FNWL.

**Acknowledgement**

I, the Primary Proposed Insured, have read, or have had read to me, the Important Notice disclosure statement given to me on this date. I (We) have read the completed Application, or have had it read to me (us), and agree that all answers are true and complete to the best of my (our) knowledge and belief and will be relied upon to determine my (our) insurability. I (We) acknowledge that this Application and any additional applications, application amendments, application supplements, questionnaires, and medical examination forms, completed and signed by me (us), are part of the Application and will be attached to, and made part of the Policy Contract, if issued. I (We) understand that receipt of the Application and any attached forms by FNWL does not guarantee a policy will be issued. **I (We) agree that: (1) I (We) will notify FNWL if any statement or answer given in any part of the Application changes prior to delivery of the Policy Contract; and (2) except as provided in the Temporary Insurance Agreement, if eligible, the insurance policy will not begin unless the first modal premium is paid and all persons proposed for insurance are living and insurable as set forth in applications attached to the Policy Contract when it is delivered to the Policy Owner on or after the issue date.** I (We) also acknowledge that I (we) have read, or have had read to me (us), the fraud warning and/or other notice listed on Form 31-4226 for my (our) state of residence, if any.

Primary Proposed Insured Signature (or parent if Primary Proposed Insured is a juvenile)	Signed at	State	on	Month, Day, Year
Proposed Policy Owner Signature (if other than Primary Proposed Insured), and title, if applicable	Signed at	State	on	Month, Day, Year
Proposed 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

I certify that I have truly and accurately recorded on this Application the information given by the Primary Proposed Insured, and Proposed Policy Owner(s). **To the best of my knowledge, there  Is  Is Not any life insurance or annuity in-force or application pending on the life of the Proposed Insured.** To the best of my knowledge, the life insurance applied for  Is  Is Not intended to replace or reduce current coverage with this or any other company. If a replacement, was sales material used in the solicitation?  Yes  No. *Copies of the materials must be submitted to FNWL and/ or the Proposed Policy Owner(s), if applicable, as required by state regulations.*

Agent Signature

Agent Name (please print or type)

Agent/Representative Code Number

Date

# Farmers New World Life Insurance Company

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**FARMERS**  
LIFE INSURANCE

Receipt Number: EA

## Receipt of Premium for Temporary Insurance Coverage

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_  
in connection with the e-Life Insurance Application bearing the same number as this receipt. If the Company declines to issue a policy, this payment will be refunded without interest. Please make check payable to Farmers New World Life.

Dated \_\_\_\_\_ Signature of Agent or Authorized Representative X \_\_\_\_\_

# Farmers New World Life Insurance Company

## Temporary Insurance Agreement for Application for Life Insurance

In consideration of the Application and payment of the modal premium, Farmers New World Life Insurance Company (FNWL) agrees to provide life insurance for a limited period of time, subject to the following conditions and limitations:

Temporary Insurance coverage applies only to the Primary Proposed Insured named in this Application, and children to be covered under a Children's Insurance Rider, and is limited to \$50,000 or the amount applied for (excluding any riders and supplemental benefits), whichever is less; and is subject to the terms, eligibility requirements and limitations stated below. Temporary Insurance coverage does not include any benefits provided under riders or supplemental benefits applied for or made a part of the policy.

### No coverage is in effect unless the following eligibility requirements are met:

1. The Primary Proposed Insured, and children to be covered under a Children's Insurance Rider, are more than 15 days and less than 70 years of age on the date this Application is signed; and
2. the Temporary Insurance Eligibility Question is truthfully answered "No" for the Primary Proposed Insured named in this Application.

**Important: If these two requirements are not met, no agent or representative of FNWL is authorized to accept money and no coverage is in effect. No agent or representative has the authority to change the terms and conditions of this Agreement.**

### Temporary Insurance coverage begins on the date:

1. The two eligibility requirements above are met; and
2. the Primary Proposed Insured, and Proposed Policy Owner(s) completes and signs this Application; and
3. the selected modal premium (in no case less than 1/12<sup>th</sup> of the minimum first year's premium) is submitted to FNWL.

Any Temporary Insurance coverage payable shall be paid to the Beneficiary(ies) listed in this Application or Children's Insurance Rider, whichever is applicable.

### Temporary Insurance coverage ends on the date:

1. The life insurance policy takes effect; or
2. the Proposed Policy Owner receives notice that either this Temporary Insurance coverage or the Application for Life Insurance has been declined; and in no case later than 12:01 a.m. Pacific Standard Time of the fifth day after FNWL has mailed a letter giving such notice; or
3. FNWL receives the Proposed Policy Owner's signed request to cancel; in which case the full amount paid will be refunded.

### No temporary benefits will be paid if:

1. The initial premium check and/or draft submitted is not honored by the bank upon first presentation; or
2. the Primary Proposed Insured, or any child to be covered under the Children's Insurance Rider, dies by suicide whether sane or insane; in which case FNWL's only obligation will be to refund the premium submitted; or
3. a material misrepresentation or omission of fact is made with respect to the eligibility requirements or the Temporary Insurance Eligibility Question; in which case Temporary Insurance coverage will be void and FNWL's only obligation shall be to return the premium paid.

# Farmers New World Life Insurance Company

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**FARMERS**  
LIFE INSURANCE

## Important Notice

### Leave this Disclosure Statement with the Primary Proposed Insured

We appreciate your Application for Life Insurance 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. You have the right to be interviewed in connection with this report. The information is secured by an independent inspection company or by Farmers New World Life through personal interviews with your friends, neighbor, 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. 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 the 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 or its reinsurers, may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization to 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 {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com. }

Farmers New World Life, 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.

# 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  
 Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008



**FARMERS**  
LIFE INSURANCE

Policy Number: \_\_\_\_\_

## Application for Life Insurance – Amendment C

A. Proposed Insured						
Name of Proposed Insured <i>(Please print: First/Middle/Last/Suffix i.e. Jr., Sr.)</i>				Height	Weight	
Occupation		Duties			Number of Years	
Employer Name				Annual Income	Annual Household Income	
B. Other Insurance In Force and Replacement <i>(Use "Additional Details" in section F, if necessary.)</i>						
Is there any life insurance <u>or annuity</u> in-force or application pending on the life of the Proposed Insured? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>						
<i>If "Yes," complete required replacement form(s) and provide details below.</i>						
Will any life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance applied for is issued? <i>If "Yes," complete required replacement form(s) and provide details below.</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>						
Company Name	Life Amount	ADB Amount	Policy Number	Will Policy be Replaced		
C. Children's Insurance Rider Information <i>(Use "Additional Details" in section F, if necessary.)</i>						
Name of Child <i>(First/Middle/Last/Suffix i.e. Jr., Sr.)</i>	Gender	Relationship	Date of Birth	Social Security Number	Height	Weight
Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, or any other disease or disorder ( <i>Indiana and Oregon residents only: during the past 10 years</i> ) ( <i>Wisconsin residents only: excluding HIV or AIDS</i> )? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>						
<i>If "Yes," provide child's name, disease or disorder, date of diagnosis, tests and medications prescribed. Include Physician, Health Care Provider and/or Hospital name, address, telephone number, and date of last visit:</i>						
D. Juvenile Plan Information <i>(Use "Additional Details" in section F, if necessary.)</i>						
List amount of life insurance on:						
Mother:		Father:		Each Child:		
If there is no insurance on one or both parents, or different amounts on other children, please explain and provide complete details:						

**E. Payor/Owner Benefit Information** *(Use "Additional Details" in section F, if necessary.)*

Name of Proposed Policy Owner *(Please print: First/Middle/Last/Suffix i.e. Jr., Sr.)*

Proposed Policy Owner's Height: Proposed Policy Owner's Weight:

Have you, the Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having any kind of cancer or tumor, stroke, diabetes, drug or alcohol dependency; or any disease or disorder of the heart, lungs, liver, or kidney; or disability, including receiving disability income benefits?  Yes  No

**If "Yes," include dates and disorders:**

**F. Additional Details** *(Use a separate sheet signed and dated by the Proposed Insured and/or Proposed Owner, if necessary.)*

**Authorization and Acknowledgement Signatures**

I (We) understand that portions or all of the data collected to create this Application for Life Insurance Amendment C (Amendment C), including my (our) signature(s), may be transmitted by electronic means 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 this Amendment C with the Policy Contract, if issued, or upon receipt of a written request directed to Farmers New World Life Insurance Company.

I (We) have read the completed Amendment C, or have had it read to me (us), and agree that all answers are true and complete to the best of my (our) knowledge and belief and will be relied upon to determine my (our) insurability. I (We) acknowledge that this Amendment C, completed and signed by me (us), is part of the Application and will be attached to, and made part of the Policy Contract, if issued.

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

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

Proposed Policy Owner Signature (if other than Proposed Insured) \_\_\_\_\_ Date \_\_\_\_\_

**To the best of my knowledge, there Is Is Not any life insurance or annuity in-force or application pending on the life of the Proposed Insured.** To the best of my knowledge, the life insurance applied for Is Is Not intended to replace or reduce current coverage with this or any other company. If a replacement, was sales material used in the solicitation? Yes No. *If "Yes," you must submit copies of the materials to Farmers New World Life Insurance Company and/or the Proposed Policy Owner(s), if applicable, as required by state regulations.*

Agent Name *(please print or type)* \_\_\_\_\_ Agent Signature \_\_\_\_\_

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

# 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*  
*Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008*



**FARMERS**  
LIFE INSURANCE

Application Number: LA

## Application for Life Insurance Part 1

<b>A. Primary Proposed Insured</b>				
Name of Primary Proposed Insured ( <i>First/Middle/Last/Suffix i.e. Jr., Sr.</i> )				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	Place of Birth ( <i>State, Country</i> )	Social Security Number (SSN)	
Marital Status	Driver License Number	License Issue State	Height	Weight
Residence Address ( <i>Street, City, State, Zip Code</i> )				
Billing Address ( <i>Street, City, State, Zip Code</i> ) ( <i>if different from Residence Address</i> )				
Primary Telephone Number		Secondary Telephone Number		Primary Language Spoken ( <i>if other than English</i> )
Occupation		Duties		Number of Years
Employer Name			Annual Income	Annual Household Income
Parent Name ( <i>if Primary Proposed Insured is a juvenile and if other than Proposed Policy Owner</i> )				
<b>B. Additional Proposed Insured</b>				
Name of Additional Proposed Insured ( <i>First/Middle/Last/Suffix i.e. Jr., Sr.</i> )				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	Place of Birth ( <i>State, Country</i> )	Social Security Number (SSN)	
Marital Status	Driver License Number	License Issue State	Height	Weight
Residence Address ( <i>Street, City, State, Zip Code</i> )				
Occupation		Duties		Number of Years
Employer Name		Relationship to Primary Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____		
<b>C. Proposed Policy Owner</b> Complete only if other than the Primary Proposed Insured. <i>Note: Complete section C for Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional).</i>				
Name of Proposed Policy Owner ( <i>First/Middle/Last/Suffix i.e. Jr., Sr.</i> )				
Primary Telephone Number		Secondary Telephone Number		Primary Language Spoken ( <i>if other than English</i> )
Relationship to Primary Proposed Insured <input type="checkbox"/> Business <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	Place of Birth ( <i>State, Country</i> )	Taxpayer ID Number or SSN	
Address ( <i>Street, City, State, Zip Code</i> )				

**D. Product Information** Plans, Benefits, and Riders may not be available in all states. Benefits and Riders may not be available for all plans.  
 (See Product Guide for Product Information)

Plan _____ Face Amount \$ _____ <input type="checkbox"/> Standard <input type="checkbox"/> Preferred <input type="checkbox"/> Premier <input type="checkbox"/> Non-nicotine <input type="checkbox"/> Nicotine <input type="checkbox"/> Juvenile Accidental Death Benefit \$ _____ { Guaranteed Insurability Benefit } { \$ _____ (juvenile policy only) } <input type="checkbox"/> Waiver of Premium (adult policy only) <input type="checkbox"/> Payor/Owner Benefits (juvenile policy only) <input type="checkbox"/> Other/Additional Insured Insurance Amount \$ _____ Children's Insurance Rider _____ units <input type="checkbox"/> Accelerated Benefit Rider for Terminal Illness (Complete disclosure form, if applicable)	Whole Life plans only - nonforfeiture options: <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-Up Insurance  Premier Whole Life only: Excess Credit Option <input type="checkbox"/> Cash <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Premium/Retirement Deposit Fund <input type="checkbox"/> Reduced Premium Single Premium Rider \$ _____ One-Year Term Rider \$ _____	Universal Life plans only: Death Benefit Option (choose one) <input type="checkbox"/> Increasing/Variable (A) <input type="checkbox"/> Level (B) <input type="checkbox"/> Automatic Increase Benefit (select no more than one of the following) <input type="checkbox"/> Waiver of Deduction <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month { Level Term 2000 (20 and 30 year) only: } <input type="checkbox"/> Critical Illness Accelerated Benefit Rider \$ _____ Benefit Amount (Complete disclosure form and Application Supplement)
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**E. Sales Illustration**

Has the Proposed Policy Owner been provided a written illustration that conforms to this Application for life insurance coverage?  
 Yes  No

**F. Payment and Billing Information** A modal billing fee may apply for payments other than annual.

Total payment submitted with application: \$ \_\_\_\_\_

**Billing Method:**

<input type="checkbox"/> Bank Check Plan <i>monthly deduction</i> (Complete a Bank Authorization form)	<input type="checkbox"/> Farmers EasyPay number _____	<input type="checkbox"/> Direct Bill (select desired frequency)
<input type="checkbox"/> Government Allotment	<input type="checkbox"/> Folio/Agent Payroll Deduction	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
<input type="checkbox"/> Other _____	<input type="checkbox"/> FIG/Farmers Employee Deduction	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly

**Universal Life Plans:** Planned Premium \$ \_\_\_\_\_ Lump Sum Payment \$ \_\_\_\_\_

**Premium/Retirement Deposit Fund:** Initial Payment \$ \_\_\_\_\_ Regular Payment \$ \_\_\_\_\_

<b>G. Other Insurance In Force and Replacement</b> Complete for all Proposed Insured(s). (Use "Other Remarks" in section P if necessary.)	Primary Proposed Insured	Additional Proposed Insured
Is there any life insurance <b>or annuity</b> in-force or application pending on the life of any Proposed Insured? If "Yes," <b>complete required replacement form(s) and</b> provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will any life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance applied for is issued? If "Yes," <b>complete required replacement form(s) and</b> provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Proposed Insured	Company Name	Life Amount	ADB Amount	Policy Number	Will Policy be Replaced?

Is the insurance applied for intended to be a 1035 Exchange? If "Yes," complete 1035 Exchange forms.  Yes  No

**H. Children's Insurance Rider Information** Complete only when Children's Insurance Rider is requested. (Use "Other Remarks" in section P, if necessary.)

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

Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, 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," provide child's name, disease or disorder, date of diagnosis, tests and medications prescribed. Include Physician, Health Care Provider and/or Hospital name, address, telephone number, and date of last visit:*

**I. Juvenile Plan Information** Complete for juvenile plan only. (Use "Other Remarks" in section P, if necessary.)

List amount of life insurance on:

Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Each Child: \_\_\_\_\_

If there is no insurance on one or both parents, or different amounts on other children, please explain and provide complete details:

**J. Payor/Owner Benefit Information** Complete only when Proposed Policy Owner is applying for Payor/Owner Benefits on a juvenile plan.

Proposed Policy Owner's Height: \_\_\_\_\_ Proposed Policy Owner's Weight: \_\_\_\_\_

Have you, the Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having any kind of cancer or tumor, stroke, diabetes, drug or alcohol dependency; or any disease or disorder of the heart, lungs, liver, or kidney; or disability, including receiving disability income benefits?  Yes  No

*If "Yes," include dates and disorders:*

**K. Proposed Insured(s) Primary Care Physician / Health Care Provider** (Use "Other Remarks" in section P, if necessary.)

Please provide name, address, and telephone number of the Primary Care Physician or Health Care Provider for all Proposed Insureds.

Proposed Insured Name:	Physician/Provider Name and Address:	Date and reason for last visit:

**L. Temporary Insurance Eligibility Question**

In the past two years, has the Primary Proposed Insured, or Additional Proposed Insured named in this Application, 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?  Yes  No

M. Supplementary Information <i>(Use appropriate "Additional Details" space in section P, if necessary.)</i>	Primary Proposed Insured	Additional Proposed Insured
1.a. Are you a United States Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.b. How long have you continuously resided in the United States?		
1.c. If not a United States Citizen, are you residing here legally with a Temporary (Non-immigrant) Visa or Permanent Resident Visa (Green Card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.d. Visa Type and Expiry date:		
2. Have you, in the past 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
3. Have you, in the past 10 years, had your driver's license suspended, revoked, or been convicted of reckless driving, or driving under the influence (DUI/DWI)? <i>If "Yes," provide date(s), type(s) of violation(s), and location (city and state):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past 10 years, pled guilty or no contest to, or been convicted of a felony? <i>If "Yes," provide date(s) of conviction(s), type(s) of felony(ies), location (city and state), and date(s) of release from court supervision:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you, in the past two years, flown as a student pilot, pilot or crewmember (or do you plan to in the future)? <i>If "Yes," complete an aviation questionnaire.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you, in the past two years, on a professional or amateur basis, participated in airborne sports, motor powered racing, mountain or rock climbing, or scuba diving (or do you plan to 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
7. Within the next two years, do you plan to travel or work outside the United States? <i>If "Yes," provide destination, purpose, dates, and length of time:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you had an application for life, accident, or health insurance, or reinstatement of a policy, declined, postponed, cancelled, or issued other than as 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

**N. Beneficiary Information** Beneficiaries by class will share and share alike unless specific percentages are noted. (Use "Other Remarks" in section P, if necessary.)

Primary Beneficiary(ies) Name(s) (First/Middle/Last/Suffix i.e. Jr., Sr.)	% of share (must total 100%)	Date of Birth (mm/dd/yyyy)	Relationship to Primary Proposed Insured
Contingent Beneficiary(ies) Name(s) (First/Middle/Last/Suffix i.e. Jr., Sr.)	% of share (must total 100%)	Date of Birth (mm/dd/yyyy)	Relationship to Primary Proposed Insured

If a Testamentary Trust is named as Beneficiary, has a will been established?  Yes  No

Include delay clause?  Yes  No If "Yes,"  15-day, or indicate number of days: \_\_\_\_\_ - days (not to exceed 180 days)

**O. Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional)**

Trust Ownership Name of Trust: \_\_\_\_\_ Trust Date: \_\_\_\_\_

Policy Co-Owner

Successor Policy Owner

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Primary Proposed Insured: \_\_\_\_\_

Social Security/Tax Identification Number: \_\_\_\_\_

**P. Additional Details / Other Remarks**

**Primary Proposed Insured's Additional Details** (Use for any explanation where space is insufficient. Indicate question number.)

Question Number    Details

**Additional Proposed Insured's Additional Details** (Use for any explanation where space is insufficient. Indicate question number.)

Question Number    Details

**Other Remarks** (Use for explanation where space is insufficient. Indicate section and give full details.)

Section    Details

**Certification, Authorization and Acknowledgement Signatures**

**Temporary Insurance Agreement (TIA) Coverage**

Farmers New World Life Insurance Company (FNWL) agrees to provide Temporary Insurance coverage on the life of the Primary Proposed Insured and Additional Proposed Insured named in this Application and children to be covered under a Children's Insurance Rider for the policy face amount applied for (not including riders or supplemental benefits) or \$50,000, whichever is less, subject to the terms, eligibility requirements, and limitations stated on page 7 of this Application. Coverage is not available to any person named in this Application or Application Supplement if:

1. The Temporary Insurance Eligibility Question in section "L" on page 3 is answered "**Yes**" or left blank by or for the Primary Proposed Insured and Additional Proposed Insured; or 2. the Temporary Insurance eligibility requirements listed on page 7 **cannot** be met for any Proposed Insured; or 3. the first full modal premium has **not** been received with this Application. I (We) represent that the answer to the Temporary Insurance Eligibility Question is true to the best of my (our) knowledge and belief. I (We) understand and agree that if the answer is found to be false, the Temporary Insurance may be denied or declined. I (We) acknowledge that I (we) have read, or have had read to me (us), the terms of the Temporary Insurance Agreement and, if the conditions have been truthfully met, I (we) have received a copy of the Receipt of Premium for Temporary Insurance Coverage and the Temporary Insurance Agreement that outlines the terms and conditions of coverage. I (We) understand that no agent or representative is authorized to change or waive the terms of this Temporary Insurance Agreement.

**Illustration**

If the Proposed Policy Owner(s) has not been provided a written illustration, I (we), as Proposed Policy Owner(s), acknowledge that no illustration conforming to the coverage being requested has been provided yet, and if required by state regulation, an illustration conforming to the policy as issued will be provided no later than at the time of the Policy Contract delivery.

**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 any of the answers above are "No," please initial and date here: \_\_\_\_\_. An IRS Form W-9 must be completed, signed and submitted 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 FNWL, its reinsurers and their authorized representatives any such information. 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 my (our) state laws address the collection, use, and disclosure of HIV/Acquired Immunodeficiency Syndrome (AIDS) related information by Insurers, I (we) will receive a separate notice regarding the collection and disclosure of HIV/AIDS related information. I (We) understand that portions or all of the data collected to create this Application for Life Insurance Part 1 (Application), including my (our) signature(s), may be transmitted by electronic means 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 this Application with the Policy Contract, if issued, or upon receipt of a written request directed to FNWL.

**Acknowledgement**

I (We) have read, or have had read to me (us), the Important Notice disclosure statement given to me (us) on this date. I (We) have read the completed Application, or have had it read to me (us), and agree that all answers are true and complete to the best of my (our) knowledge and belief and will be relied upon to determine my (our) insurability. I (We) acknowledge that this Application and any additional applications, application amendments, application supplements, questionnaires, and medical examination forms, completed and signed by me (us), are part of the Application and will be attached to, and made part of the Policy Contract, if issued. I (We) understand that receipt of the Application and any attached forms by FNWL does not guarantee a policy will be issued. **I (We) agree that: (1) I (We) will notify FNWL if any statement or answer given in any part of the Application changes prior to delivery of the Policy Contract; and (2) except as provided in the Temporary Insurance Agreement, if eligible, the insurance policy will not begin unless the first modal premium is paid and all persons proposed for insurance are living and insurable as set forth in applications attached to the Policy Contract when it is delivered to the Policy Owner on or after the issue date.** I (We) also acknowledge that I (we) have read, or have had read to me (us), the fraud warning and/or other notice listed on Form 31-4226 for my (our) state of residence, if any.

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

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

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

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

\_\_\_\_\_  
**Additional Proposed Insured Signature**

\_\_\_\_\_  
**Proposed 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

I certify that I have truly and accurately recorded on this Application the information given by the Primary Proposed Insured, Additional Proposed Insured, and Proposed Policy Owner(s). **To the best of my knowledge, there Is Is Not any life insurance or annuity in-force or application pending on the life of the Proposed Insured.** To the best of my knowledge, the life insurance applied for Is Is Not intended to replace or reduce current coverage with this or any other company. If a replacement, was sales material used in the solicitation? Yes No. If "Yes," you must submit copies of the materials to FNWL and/or the Proposed Policy Owner(s), if applicable, as required by state regulations.

\_\_\_\_\_  
**Agent Name** (please print or type)

\_\_\_\_\_  
**Agent Signature**

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

\_\_\_\_\_  
**Date**

# 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  
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FARMERS  
LIFE INSURANCE

Receipt Number: LA

## Receipt of Premium for Temporary Insurance Coverage

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_  
in connection with the Application for Life Insurance Part 1 bearing the same number as this receipt. If the Company declines to issue a policy, this payment will be refunded without interest. Please make check payable to Farmers New World Life.

Dated \_\_\_\_\_ Signature of Agent or Authorized Representative X \_\_\_\_\_

## Farmers New World Life Insurance Company

### Temporary Insurance Agreement for Application for Life Insurance

In consideration of the Application and payment of the modal premium, Farmers New World Life Insurance Company (FNWL) agrees to provide life insurance for a limited period of time, subject to the following conditions and limitations:

Temporary Insurance coverage applies only to the Primary Proposed Insured, and Additional Proposed Insured named in this Application, and children to be covered under a Children's Insurance Rider, and is limited to \$50,000 or the amount applied for (excluding any riders and supplemental benefits), whichever is less; and is subject to the terms, eligibility requirements and limitations stated below. Temporary Insurance coverage does not include any benefits provided under riders or supplemental benefits applied for or made a part of the policy.

#### No coverage is in effect unless the following eligibility requirements are met:

1. The Primary Proposed Insured, Additional Proposed Insured, and children to be covered under a Children's Insurance Rider, are more than 15 days and less than 70 years of age on the date this Application is signed; and
2. the Temporary Insurance Eligibility Question is truthfully answered "No" for the Primary Proposed Insured and Additional Proposed Insured named in this Application.

**Important: If these two requirements are not met, no agent or representative of FNWL is authorized to accept money and no coverage is in effect. No agent or representative has the authority to change the terms and conditions of this Agreement.**

#### Temporary Insurance coverage begins on the date:

1. The two eligibility requirements above are met; and
2. the Primary Proposed Insured, Additional Proposed Insured, and Proposed Policy Owner(s) completes and signs this Application; and
3. the selected modal premium (in no case less than 1/12<sup>th</sup> of the minimum first year's premium) is submitted to FNWL.

#### Temporary Insurance coverage ends on the date:

1. The life insurance policy takes effect; or
2. the Proposed Policy Owner receives notice that either this Temporary Insurance coverage or the Application for Life Insurance has been declined; and in no case later than 12:01 a.m. Pacific Standard Time of the fifth day after FNWL has mailed a letter giving such notice; or
3. FNWL receives the Proposed Policy Owner's signed request to cancel; in which case the full amount paid will be refunded.

#### No temporary benefits will be paid if:

1. The initial premium check and/or draft submitted is not honored by the bank upon first presentation; or
2. the Primary Proposed Insured, Additional Proposed Insured, or any child to be covered under the Children's Insurance Rider, dies by suicide whether sane or insane; in which case FNWL's only obligation will be to refund the premium submitted; or
3. a material misrepresentation or omission of fact is made with respect to the eligibility requirements or the Temporary Insurance Eligibility Question; in which case Temporary Insurance coverage will be void and FNWL's only obligation shall be to return the premium paid.

Any Temporary Insurance coverage payable shall be paid to the Beneficiary(ies) listed in this Application or Children's Insurance Rider, whichever is applicable.

# 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*

*Variable Policy Service Office: P.O. Box 724208, Atlanta, GA 31139 (877) 376-8008*



**FARMERS**  
LIFE INSURANCE

## Important Notice

### Leave this Disclosure Statement with the Primary Proposed Insured and Additional Proposed Insured

We appreciate your Application for Life Insurance 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. You have the right to be interviewed in connection with this report. 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. 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 the 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 or its reinsurers, may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization to 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 {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com.}

Farmers New World Life, 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.

# Farmers New World Life Insurance Company

Merger Island Life Office: 3003 77th Ave. S.E., Mercer Island, WA 98040-2890 (206) 232-8400



**FARMERS**  
LIFE INSURANCE

## Annuity Application

AE

Proposed Annuitant					
Name of Proposed Annuitant (First/Middle/Last/Suffix i.e. Jr., Sr.)				Sex <u>Gender</u>	Birth date
Mailing Address (Number, Street, City, State, Zip Code)					
Taxpayer I.D. Number/SSN		Marital Status	(Area) Home Phone No.	(Area) Business Phone No.	
Owner (if other than Proposed Annuitant)					
Name of Owner (First/Middle/Last/Suffix i.e. Jr., Sr.)				Birth date	
Mailing Address (Number, Street, City, State, Zip Code)					
Taxpayer I.D. Number/SSN		Relationship to Proposed Annuitant	(Area) Home Phone No.	(Area) Business Phone No.	
Beneficiary Designation					
Primary Beneficiary	Age	Relationship	Contingent Beneficiary	Age	Relationship
Annuity Information					
Plan Code	Initial / Single Payment \$	Planned Payment (If applicable) \$	Frequency of Payment (If applicable)	For Tax Year	
Check only one: <input type="checkbox"/> Non-Qualified <input type="checkbox"/> Traditional IRA <input type="checkbox"/> SIMPLE IRA <input type="checkbox"/> SEP IRA <input type="checkbox"/> Roth IRA <input type="checkbox"/> TSA <input type="checkbox"/> Qualified Pension Plan					
Check if applicable: <input type="checkbox"/> 1035 Exchange <input type="checkbox"/> Transfer <input type="checkbox"/> Rollover (within 60 days) <input type="checkbox"/> Conversion <input type="checkbox"/> Recharacterization					
- Please see reverse for description of plans; and 1035 Exchanges, Transfers, Rollovers, Conversions, and Recharacterizations.					
- If applicable, indicate the full name, address, and telephone number of the company sending funds, in the "Remarks/Instructions" below.					
<u>Does the Proposed Annuitant have any life insurance or annuity in-force or application pending?</u> (If "Yes," complete required replacement form(s).) Proposed Annuitant Response: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Proposed Annuitant: (a) stop paying premiums, (b) reduce the face amount, or (c) otherwise discontinue any existing life insurance or annuity if this annuity is issued? (If so, include the name and address of the existing company in the "Remarks/Instructions" space below). (If "Yes," complete required replacement form(s).) Proposed Annuitant Response: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide company name & address.					
Remarks/Instructions:					

### Acknowledgement and Declaration

- I agree that this application will become a part of the contract issued by Farmers New World Life. I declare to the best of my knowledge and belief that the statements and answers to the questions on this Annuity Application are true and complete.
- My agent has discussed with me the guaranteed death and income benefit features which are unique to annuities. I understand that any traditional IRA, SIMPLE IRA, SEP IRA, Roth IRA, TSA, or Qualified Pension Plan that I may purchase is tax deferred, and acknowledge that this annuity is not being purchased solely for its tax deferral feature.

### Taxpayer Certification (please see reverse for additional information)

Under penalties of perjury, I, as Owner, certify that:

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

**Certification Instructions.** Item 2. above does not apply to real estate transactions. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct taxpayer identification number (TIN).

**Arizona Residents:** On written request we will provide you, within a reasonable period of time, reasonable factual information regarding the benefits and provisions of this policy. If, for any reason, you are not satisfied with this policy, you may return it to your agent or to the address above within 30 days after the policy is delivered. You will receive a refund of all premiums paid (contract value for non-qualified variable annuities).

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

**Please attach check payable to Farmers New World Life. Do not make check payable to agent, or leave payee blank.**

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed  
at

Proposed Annuitant Signature (or parent if Proposed Annuitant is a juvenile) \_\_\_\_\_ City, State \_\_\_\_\_ on \_\_\_\_\_ Month, Day, Year \_\_\_\_\_

Owner Signature (if other than Proposed Annuitant)

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

To the best of your knowledge, is there any life insurance or annuity in-force or application pending on the life of the Proposed Annuitant?  
(If "Yes," forward required replacement form(s).)..... Agent Response:  Yes  No

To the best of your knowledge, will Proposed Owner/Annuitant stop paying premiums, reduce the face amount, or otherwise discontinue any existing life insurance or annuity if this annuity is issued? (If "Yes," forward required replacement form(s).)..... Agent Response:  Yes  No

**Agent Name** (please print or type)

Agent Code Number

**Agent Signature**

## Plan Descriptions

**Non-Qualified Annuity** - Contributions are made by an individual, trust, estate or business entity and are not tax-deductible. Interest earned is tax-deferred until: (1) an assignment; (2) the annuity is owned by a "non-natural" person (e.g. a trust); or (3) a distribution is made. Upon assignment, withdrawal or distribution, only earnings (interest credited/gain) are included in taxable income. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Traditional Individual Retirement Annuity (IRA)** - Contributions are made by an individual, and may be **tax-deductible** depending on income and whether the IRA owner is covered by an employer-sponsored retirement plan. Interest is tax-deferred until the time of distribution. At distribution, 100% of funds withdrawn may be subject to taxation. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty. **Deposits made between January 1st and April 15th of each year must identify the tax year to which it is to be applied.**

**Savings Incentive Match Plan for Employees (SIMPLE) IRA** - Contributions are funded using employee salary reduction contributions; and either employer matching or non-elective contributions. Contributions are not included in the employee's gross income, and are tax-deductible by the employer. Annuity is owned by the employee. Interest is tax-deferred until the time of distribution. At distribution, 100% of withdrawal is taxable. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Simplified Employee Pension (SEP) IRA** - Contributions are made by the employer, employee, or both. If an employer contribution is to be made for any plan year, it must be made for every eligible employee. Employer contributions are not included in employee's gross income. The employee may also make additional contributions to the SEP IRA (or to a separate IRA) subject to traditional IRA rules. Annuity is owned by the employee. Interest is tax-deferred until the time of distribution. At distribution, 100% of withdrawal may be subject to taxation. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty. **All deposits must be identified as to whether they are employer contributions, or the employee's personal (traditional) IRA contribution. Employee's personal (traditional) IRA contributions made between January 1st and April 15th of each year must identify the tax year to which it is to be applied.**

**Roth IRA** - Contributions are made by an individual, and are not tax-deductible. Interest is tax-deferred until the time of distribution. At time of distribution, the annuity owner will not be taxed on the principal. Earnings (interest credited/gain) may or may not be taxed, depending on the circumstances. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Tax-Sheltered Annuity (TSA)** - Contributions are made by the employer, and not included in the employee's gross income. Tax-sheltered annuities are for employees of tax-exempt educational organizations, religious organizations, and charitable organizations. Annuity is owned by the employee. Interest is tax-deferred until the time of distribution. At distribution, 100% of withdrawal is taxable. Distributions prior to age 59½ may be subject to IRS 10% premature distribution penalty.

**Qualified Pension Plans** - Contributions are made by the employer directly to FNWL, or to a Pension Trust account. Contributions are tax-deductible by the employer and not included in the employee's gross income. Interest is tax-deferred until the time of distribution. Distributions to the employee prior to age 59½ may be subject to IRS 10% premature distribution penalty. Plans must be non-discriminatory, i.e.; they must provide participation for all eligible employees. FNWL's Qualified Pension Plan does not include SEP IRAs or TSAs; nor can it be a profit-sharing plan. The owner should consult with a tax adviser to determine which, if any, Adoption Agreement (Profit Sharing ~~31-1182~~ or Money Purchase ~~31-1183~~) will coincide with the Prototype Defined Contribution Plan packet (~~31-1184~~).

**1035-Exchange** - An in kind exchange for certain insurance policies, and non-qualified annuity contracts, as permitted under Section 1035 of the Internal Revenue Code. New policies or contracts can be issued that maintain the original cost basis; and therefore remain tax-deferred.

**Transfer** - Funds are moved, tax-deferred, from one financial institution directly to another. The policy owner does not handle the funds.

**Rollover** - Funds from a traditional IRA, SEP IRA, SIMPLE IRA, or Roth IRA, are distributed to the owner who then must roll the funds over into the same type of account within 60 days of receipt. Funds from a SEP IRA, SIMPLE IRA (after two years of participation in the plan), TSA, or Qualified Pension Plan, are distributed to the owner who then must roll the funds over into a traditional IRA within 60 days of receipt to qualify as a non-taxable rollover. Non-qualified annuities cannot be established with rollover funds.

**Conversion** - Funds are transferred, or rolled over, from a traditional IRA, SEP IRA, or SIMPLE IRA (after two years) to a Roth IRA. In the year of conversion you must pay tax on the distribution, but no IRS 10% premature distribution penalty.

**Recharacterization** - Funds converted to a Roth IRA are moved via a trustee to trustee transfer back to the same type of IRA account that they came from. A regular contribution to a Roth IRA is moved to a traditional IRA (or the reverse). The recharacterization must be completed by your federal income tax return due date (plus extensions) for the tax year of conversion or contribution (or such later date as provided by the IRS).

### Purpose of the Taxpayer Certification

If you certify: 1) on the front side of this application that you are not subject to backup withholding because of underreporting interest and dividends; and 2) if you give the payer the correct Taxpayer Identification Number (TIN), the payer will not be required to withhold ~~30~~28% of payments made to you.

**Penalties** - If you fail to furnish your correct TIN to a **payer requester**, you are subject to a penalty of \$50 for each **such** failure unless your failure is due to reasonable cause and not to willful neglect. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fine and/or imprisonment.

**Name** - Be sure to enter your correct name. If you are an individual and your name has changed, contact the Social Security Administration to report your new name.

**Privacy Act Notice** - Section 6109 of the Internal Revenue Code requires most recipients of dividend, interest, or other payments to give taxpayer identification numbers to payers who must report the payments to the IRS. IRS uses the numbers for identification purposes. Payers must be given the numbers whether or not recipients are required to file tax returns. Payers must generally withhold ~~30~~28% of taxable interest, dividend, and certain other payments to a payee who does not furnish a taxpayer identification number to a payer. Certain penalties may also apply.

### Agent

Additional forms may be required before an annuity can be issued. Please consult LifeNet, or publications 31-0719 and 31-0798 for further details.