

SERFF Tracking Number: FNWW-127297741 State: Arkansas
Filing Company: Farmers New World Life Insurance Company State Tracking Number: 49379
Company Tracking Number: LIFE- DISABILITY INCOME RIDER
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Disability Income Rider
Project Name/Number: DISABILITY INCOME RIDER/

Filing at a Glance

Company: Farmers New World Life Insurance Company

Product Name: Disability Income Rider SERFF Tr Num: FNWW-127297741 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num: 49379

Sub-TOI: L08.000 Life - Other Co Tr Num: LIFE- DISABILITY INCOME RIDER State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird
Disposition Date: 08/03/2011
Authors: Christine Andreason,
Peter Lindstrom, Patrice Norgate,
Natalie Volz
Date Submitted: 07/22/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: DISABILITY INCOME RIDER
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/03/2011
State Status Changed: 08/03/2011
Created By: Christine Andreason
Corresponding Filing Tracking Number:

Deemer Date:
Submitted By: Christine Andreason
Filing Description:
LIFE DISABILITY RIDER

Form: 2011-TERM DIR
DIR Supplement

SERFF Tracking Number: FNWW-127297741 State: Arkansas
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We are submitting the above forms for your review and approval. These forms are new and not intended to replace any forms previously approved by the Department.

The Disability Income Rider is intended for the general public; issue ages 18-55 and will be marketed on an individual basis through licensed producers.

The rider will be issued with our Level Term policies. The approval dates for these three plans in your state are attached to the Supporting Documentation tab.

Subject to the terms and conditions set forth in the form, the rider will provide a monthly disability benefit if the rider insured is totally disabled from illness or injury.

The minimum monthly Benefit Amount is \$1,000 and the maximum is \$5,000.

This rider or the policy it is attached to is not illustrated.

The Disability Rider Application Supplement will be used to apply for the benefit.

Included in the filing are an Actuarial Memorandum and any state certifications that may be required.

Bracketed, variable information is found in the Officer Title and Signature field, in the address block on the application supplement, and on the specification page. Attached is a Statement of Variability describing the bracketing parameters on the specification page.

Your review and approval of this submission is greatly appreciated.

Christine Andreason

Company and Contact

Filing Contact Information

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

Filing Company Information

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

SERFF Tracking Number: FNWW-127297741 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: 2 forms at \$50.00 each for a total of \$100.00.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Farmers New World Life Insurance Company	\$100.00	07/22/2011	50024445

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2011	08/03/2011

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Disposition

Disposition Date: 08/03/2011

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	Approval dates of policies this rider will be attached to.		Yes
Supporting Document	Specifications Page		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Statement of Variability		Yes
Form	Disability Income Rider		Yes
Form	Disability Income Rider Application Supplement		Yes

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Form Schedule

Lead Form Number: 2011-Term DIR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	2011-Term DIR	Policy/Cont Disability Income ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		58.000	2011-Term DIR.pdf
	DIR Supp	Application/Disability Income Enrollment Rider Application Form Supplement	Initial		64.500	DIR Supp.pdf

FARMERS NEW WORLD LIFE INSURANCE COMPANY

DISABILITY INCOME RIDER

DEFINITIONS **Care**

Regular and personal treatment from a licensed Physician which is appropriate for the Covered Illness or Covered Injury according to generally accepted medical standards.

Covered Illness

Subject to the Proof of Eligibility requirements, an Illness that:

1. is a disease, bodily infirmity, sickness, infection or any other physical or mental condition that causes the Disability Income Insured to be Totally Disabled;
2. first manifests itself to the Disability Income Insured after the Waiting Period, and
3. occurs while this rider is in force.

Covered Injury

Subject to the Proof of Eligibility requirements, an injury that is the result of an accident, which is something out of the usual course of events that:

1. happens:
 - a. suddenly and unexpectedly; and
 - b. without the design or intent of the person injured; and
2. causes the Disability Income Insured to be Totally Disabled; and
3. occurs while this rider is in force.

Diagnosis/Diagnosed

The definitive establishment, acceptable to Us, of the Covered Illness or Covered Injury through the use of clinical and/or laboratory findings and subject to the terms and conditions of this rider. The Diagnosis must be made by a Physician as defined in this rider.

Disability Income Insured

The Primary Proposed Insured named on the application for life insurance under the Policy. No other Insured covered under the Policy or its riders is included as a Disability Income Insured.

Elimination Period

The number of consecutive days stated on the Policy Specifications page during which the Disability Income Insured must be Totally Disabled prior to being eligible for the Monthly Disability Benefit.

No Monthly Disability Benefit will be paid during the Elimination period. The first day of the Elimination period begins on the first day of Total Disability and not on the date of the Covered Illness begins or Covered Injury occurs. Benefits do not accumulate during the Elimination Period.

Gainfully Employed or Gainful Employment

Employed or self-employed for monetary gain or reward.

Material and Substantial Duties

Those duties that are required for the performance of the Disability Income Insured's Regular Occupation, and cannot be reasonably omitted or modified. Substantial Duties refers to proportionate time spent, is an identifiable quantitative determination, and suggest the performance of specific Occupation duties for the majority of an 8-hour work day. Four (4) hours per day is considered to be part-time. Material Duties refers to specific job-related tasks and is generally a qualitative measurement.

Performing a duty at a particular work site, place or building is not a Material and Substantial Duty of the Disability Income Insured's Regular Occupation, provided the Disability Income Insured's employer will allow the Disability Income Insured to perform such duty at a different work site, place or building.

Maximum Number of Monthly Benefit Payments

The maximum number of Monthly Disability Benefit Payments that will be paid, regardless of how long the Disability Income Insured is Totally Disabled. The Maximum Number of Monthly Benefit Payments is specified on the Policy Specifications page.

Monthly Disability Benefit

The amount of monthly benefit stated on the Policy Specifications page and payable due to the Disability Income Insured's Total Disability, subject to the provisions, limitations and exclusions in this rider. The Monthly Disability Benefit amount may not exceed 1.5% of the Principal Sum of the policy to which this rider is attached, unless the policy Principal Sum is reduced solely due to payment of a claim for accelerated benefits.

Occupation

A business, trade, profession, or vocation.

Physician

A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctoral level Psychologist, whose specialty is appropriate for the Disability Income Insured's Covered Illness or Covered Injury, practicing within the scope of his or her license issued by the jurisdiction in which such person's services are rendered. Such jurisdiction must be within the United States of America, its territories, or Canada. The Physician may not be:

1. The Disability Income Insured;
2. the Policy Owner;
3. a Family Member;
4. a person who practices in the same medical group as the Disability Income Insured, Policy Owner, or a Family Member;
5. a business partner of the Disability Income Insured, Policy Owner, or a Family Member; or
6. a person living at the same address as the Disability Income Insured, Policy Owner, or a Family Member.

"Family Member" is defined as the Disability Income Insured's or Policy Owner's spouse/domestic partner/civil union partner and anyone who is related to the Disability Income Insured, Policy Owner, Disability Income Insured's or Policy Owner's spouse/domestic partner/civil union partner by the following degree of blood, marriage, adoption, or operation of law: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, nephews and nieces.

Regular Occupation

An Occupation of the same general character as the Occupation for which the Disability Income Insured is receiving or has received wages or compensation during the six (6) month period immediately preceding the Total Disability.

Rider Effective Date

The Rider Effective Date listed on the Policy Specifications page.

Total Disability/Totally Disabled

A condition occurring such that the Disability Income Insured is:

1. continuously and totally unable to perform the Material and Substantial Duties of the Disability Income Insured's Regular Occupation as a result of one or more Covered Illness(es) and/or Covered Injury(ies);
2. under the regular and appropriate Care of a Physician for treatment arising from and related to the Covered Illness or Covered Injury causing Total Disability; and
3. not Gainfully Employed in any other Occupation.

Loss of professional or occupational license or certification for non-medical reasons is not considered a Total Disability.

Waiting Period

For Covered Illnesses, the period of thirty (30) consecutive days beginning on the later of the Rider Effective Date or the effective date of any rider reinstatement.

The Covered Illness must first occur after the Waiting Period. If the Disability Income Insured's illness occurs during the Waiting Period, no Monthly Disability Benefit is payable. An illness shall be considered to have first occurred when symptoms or laboratory and/or clinical findings that lead to the Diagnosis of a Covered Illness are first documented in the Disability Income Insured's medical records regardless of the date upon which the Diagnosis is actually made.

TOTAL DISABILITY BENEFIT

Monthly Disability Benefit Payment

We will pay to the Policy Owner the Monthly Disability Benefit minus any premiums for the Policy and riders that are due and unpaid, subject to the terms and conditions of this rider and only when:

1. The Disability Income Insured is Diagnosed by a Physician as having a Covered Illness or Covered Injury that caused Total Disability;
2. We receive Proof of Eligibility of the Disability Income Insured's continued Total Disability after the end of the Elimination Period; and
3. Total Disability begins while this rider is in force.

Conditions for Payment

Payment of the Monthly Disability Benefit is subject to all of the following conditions:

1. The Monthly Disability Benefit payable under this rider will not exceed the Monthly Disability Benefit stated on the Policy Specifications page;
2. We must receive Proof of Eligibility that is acceptable to Us;
3. We will not pay benefits under this rider for any period of disability during which the Disability Income Insured is not under the Care of a Physician. Such Care must be appropriate, according to generally accepted medical standards for the condition which is causing the disability, and must be provided by a Physician whose specialty is appropriate for the Disability Income Insured's Covered Illness or Covered Injury; and
4. The Disability Income Insured has been Gainfully Employed at any time during the six (6) months immediately preceding Total Disability.

When Benefits Begin

After Conditions for Payment, Proof of Eligibility, and the Waiting Period have been satisfied, the Monthly Disability Benefit will be paid at the end of each calendar month.

When Benefits End

We will continue to pay the Monthly Disability Benefit until the earliest of:

1. the Maximum Number of Monthly Benefit Payments has been made;
2. when Proof of Eligibility of the Disability Income Insured's continued Total Disability is not provided in accordance with this rider;
3. the date on which the Disability Income Insured is no longer Totally Disabled;
4. the date on which the Disability Income Insured returns to Gainful Employment in any Occupation; or
5. when this Rider ends as outlined in the Termination of Rider provision.

Concurrent Disability

A Concurrent Disability occurs when there is more than one injury or illness resulting in a Total Disability. When there is more than one factor causing Total Disability, the Monthly Disability Benefit is paid as if there is only one Covered Injury or Covered Illness. The Disability Income Insured will be considered to have one Total Disability.

Recurrent Disability

If, within four (4) months following the end of a previously covered period of Total Disability, We receive proof, satisfactory to Us, that the Disability Income Insured has a Total Disability that is solely due to the same or related Covered Illness or Covered Injury that caused the previous period of Total Disability, We will not apply a new Elimination Period.

If the Disability Income Insured's previous Total Disability did not last beyond the Elimination

Period, the balance of the Elimination Period will apply to this subsequent period of Total Disability. The Recurrent Disability provision does not apply beyond the termination of this Rider as outlined in the Termination of Rider provision.

If a Total Disability arises from a different cause, We will consider it to be a separate and unrelated period that is subject to a new Elimination Period.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations

In addition to any other conditions, exclusions or limitations set forth in this rider, this rider will provide no benefit if the Total Disability is caused in whole or in part by, occurs during or results in whole or in part from:

1. Actions of the Disability Income Insured intended or expected to result in injury;
2. suicide or attempt at suicide, intentional self-inflicted injury, or any attempt at intentional self-inflicted injury, while sane or insane;
3. being intoxicated or under the influence (including overdose) of an excitant, depressant, hallucinogen, narcotic, or any drug, alcohol or intoxicant, including those prescribed by a Physician that are misused by the Disability Income Insured;
4. participation in the commission of or attempt to commit a felony or assault;
5. engagement in an illegal activity or Occupation;
6. voluntary participation in any riot or insurrection;
7. active-duty military service;
8. operating, learning or instructing to operate, or serving as a crew member of an aircraft or hot air balloon, including those which are not motor driven, or jumping, parachuting, or falling from an aircraft or hot air balloon;
9. engaging in hang gliding, bungee jumping, parachuting, sail gliding, parasailing or parakiting, or any similar aerial activity;
10. riding in or driving any motor vehicle in a race, stunt show or speed test;
11. practicing for or participating in any semiprofessional or professional competitive athletic contest for which the Disability Income Insured receives any type of compensation;
12. operating any type of land, water or air vehicle while having a blood alcohol content at or above the level made illegal for operation of such vehicle by the jurisdiction where the accident occurred;
13. psychiatric or psychological condition including, but not limited to, affective disorders, neuroses, anxiety, stress, depression, adjustment reactions, post-traumatic stress disorder, or Gulf-War Syndrome. However, Alzheimer's Disease or similar forms of senility or senile dementia, which are first manifested after the Waiting Period, are covered under the rider;
or
14. childbirth or pregnancy except for Total Disability due to Complications of Pregnancy. A complication of pregnancy means any disease, disorder, emergency non-elective cesarean section or condition whose diagnosis is distinct from pregnancy but is adversely affected by or caused by pregnancy and which requires the care of a Physician. Conditions which are not complications include, but are not limited to, conditions, occurrences and procedures such as morning sickness, false labor, and Physician prescribed rest during the period of pregnancy, and conditions associated with management of a difficult pregnancy which do not constitute a categorically distinct complication of pregnancy.

In addition, We will not pay benefits:

1. During any period of time in which the Disability Income Insured is incarcerated; or
2. if a Covered Illness causing Total Disability first manifests itself to the Disability Income Insured prior to, or during the Waiting Period.

**CLAIM
PROVISIONS**

Notice of Claim for Total Disability

Written Notice of Claim must be given to Us at our Home Office during the Disability Income Insured's continuing Total Disability and while the Disability Income Insured is alive, within ninety (90) days of the Insured's Total Disability or as soon as reasonably possible, but in no case later than one year after the start of Total Disability. The notice must be given to Us at Our Home Office in form and content acceptable to Us. The notice should include the Disability Income Insured's name, Policy number and Covered Illness or Covered Injury.

Proof of Eligibility

We must receive written proof of the Disability Income Insured's Total Disability, in form and content acceptable to Us, within ninety (90) days of the Policy Owner's Notice of Claim before We will pay the Monthly Disability Benefit. This proof will include properly completed Claim Forms, which we will provide to the Policy Owner upon Notice of Claim for Total Disability, a Physician's Statement of Total Disability, and medical information acceptable to us supporting the statement. We may require additional medical information from the Physician submitting the statement and from other Physicians, specialists, or institutions having knowledge of the Disability Income Insured's Total Disability.

If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible, but not later than one year after the start of the Insured's Total Disability.

Physical Examination

At Our expense, We reserve the right to have a Physician of Our choosing examine the Disability Income Insured prior to paying the Monthly Disability Benefit, and as often thereafter as We deem reasonably necessary to determine the validity of the Policy Owner's claim. We reserve the right to rely on the Physician We choose for claim purposes.

**EFFECT ON
THE POLICY**

Continuing Premium Requirement

During a period of Total Disability, any premium payments due under the Policy, including any riders, must be paid by the Policy Owner in accordance with the terms and conditions of the Policy and such riders, unless the premiums are waived in accordance with the terms and conditions of a Waiver of Premium rider attached to the Policy.

Other Benefits and Riders

If the Disability Income Insured is Diagnosed with a Covered Illness or Covered Injury that causes Total Disability under this Disability Income Rider, there will be no automatic qualification for any other benefit(s) provided by any benefit, rider or policy issued by Us. Qualification will be based solely on the terms and conditions of such rider or policy.

Qualification for benefits under other benefits, riders or policies will not provide automatic qualification for benefits under this Disability Income Rider.

**GENERAL
PROVISIONS**

Contract

This rider is subject to all terms of the Policy except as modified in this rider.

Conversion

This rider has no Conversion option. The benefits of this rider will terminate if the Policy Owner exercises the Conversion option of the Policy for the full Principal Sum.

Guaranteed Values

This rider does not increase or decrease any Guaranteed Values of the Policy.

Premium and Renewal

The initial annual premium for this rider is shown on the Policy Specifications page.

Premiums may increase each year after the second anniversary of the Rider Effective Date.

Premiums for this rider will only increase if premiums are increased for every Disability Income

Rider with the same benefit amount, premium class, issue age, gender and other characteristics that affected the initial premium of this Disability Income Rider.

Proceeds

Any proceeds paid under the Policy will not be reduced by any Monthly Benefit Amount paid by this rider unless such payment was for a period after the Disability Income Insured's death. If payment is made for a period after the Disability Insured's death, the policy proceeds will be reduced by the amount of such payment(s).

Any Monthly Benefit Amount due to the Policy Owner for period(s) prior to the Disability Insured's death, but unpaid at the time of the Disability Income Insured's death, will be paid to the Policy Owner, or to the Policy Owner's Estate if the Policy Owner is deceased.

Reinstatement

This rider may be reinstated subject to the terms and conditions defined in the Reinstatement Provision and the Automatic Reinstatement Provision of the Policy. Reinstatement of the Policy does not guarantee reinstatement of this rider.

The Disability Income Insured covered under any reinstated rider will be subject to the terms and conditions in this rider.

Termination of Rider

This rider will end when:

1. The Disability Income Insured Attains Age 65 and is not Totally Disabled;
2. the Policy Owner is receiving benefits beyond the Disability Income Insured's Age 65 under this rider and the Disability Income Insured is no longer Totally Disabled;
3. the Disability Income Insured's Covered Illness occurs during the Waiting Period;
4. the Monthly Disability Benefit has been paid for the Maximum Number of Monthly Benefit Payments;
5. We receive the Policy Owner's written request to cancel this rider;
6. We receive the Policy Owner's written request to convert the full Policy Principal Sum to permanent insurance;
7. the Policy ends for any reason; or
8. the Disability Income Insured dies.

Attached to and made a part of the Policy as of the effective Date of this Rider.

FARMERS NEW WORLD LIFE INSURANCE COMPANY



Thomas J. White
President



John R. Patton
Assistant Secretary

Farmers New World Life Insurance Company

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



FARMERS
LIFE INSURANCE

Disability Income Rider Application Supplement

A. Primary Proposed Insured *On this application supplement, "You" is the Primary Proposed Insured designated on the life insurance application.*

Name of Primary Proposed Insured (<i>First/Middle/Last/Suffix i.e., Jr., Sr.</i>)	Policy Number
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B. Benefit Amount Requested

I am applying for a Monthly Disability Benefit Amount of \$_____

I am applying for: Class 1 Class 2 Class 3

C. Details of Existing Disability Income Coverage & Other Coverage Applied for

1. Do you have any disability income insurance in force or pending? Yes No
If "yes," please provide details:

2. Will you reduce, replace, discontinue, or stop paying any existing disability income insurance if coverage applied for is issued? Yes No
If "yes," please provide details:

Policy Number to be Replaced	Type of Coverage	Company	Monthly Disability Income Benefit Amount	Length of Benefit Period
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Other: _____			
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Other: _____			
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Other: _____			

3. Have you had an application for disability, disability income, health, dread disease or critical illness insurance declined, postponed, cancelled, issued differently than applied for or modified in any way? Yes No
If "yes," please provide details:

D. Regular Occupation *Submit with your application: Last month's proof of income (pay stub, with year-to-date earnings) or, if self-employed, Federal Income Tax Returns for the last 2 years.*

1. Describe the specific tasks performed at your Regular Occupation:

2. Indicate the percentage of time spent at your Regular Occupation doing the following (*total must equal 100%*):

- a) Sedentary or very minimally active office or desk work: _____%
- b) Lightly-active duties (examples: walking, traveling, meeting with clients): _____%
- c) Light labor (examples: house cleaning, tiling, finish carpentry, daycare): _____%
- d) Heavy labor (examples: general construction, steel work, truck driving) _____%

3. Number of hours worked each week at your Regular Occupation:

- 0 – 20
- 21 – 30
- 31 – 40
- More than 40

a) Annual Earned Income \$ _____

Annual earned income before taxes from wages, salary, tips and commissions. If self-employed, list net annual earned income (after business expenses are deducted).

E. Complete if Self-Employed

a) Type of Business	b) Name of business and type of service(s) provided
c) Number of Employees	d) Time self-employed in this business ____ years ____ months If less than 2 years, list occupation prior to self-employment:

e) Is your business located within your home?..... Yes No

If “yes”, please provide the percentage of time you work away from your home _____%

F. Additional Information *Please include all details to any “Yes” answers or any additional information in the Additional Details Section below.*

- 1. In the past 10 years have you consulted a healthcare provider, been treated, tested, hospitalized or taken medication for, or had any of the following:
 - a) Arthritis, gout, osteoporosis, or other disease or disorder of the muscles, bones, spine (back/neck) or joints? . Yes No
 - b) Any disease or disorder of the eyes, ears, nose or throat? Yes No
- 2. In the past 5 years have you lost work for more than 10 days annually due to illness or injury?..... Yes No
- 3. In the past 5 years have you received disability benefits from any source for any reason?..... Yes No
- 4. Have you ever been disabled or unable to work due to disability?..... Yes No

G. Additional Details

Authorization and Acknowledgement Signatures

I (We) understand that portions or all of the data collected to create this Disability Income Application Supplement (Supplement), 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 and confirm that I (we) have not withdrawn my (our) consent. I (We) will receive a paper copy of this Supplement, which will become part of the Policy Contract, if issued. In the event this Supplement is completed with the Application for Policy Change/Reinstatement, I (we) will receive a copy of this Supplement if the request is approved. I (We) will also receive a copy upon receipt of a written request directed to Farmers New World Life Insurance Company.

I (We) have read the completed Supplement, or have had it read to me (us), and agree that all the answers are true and complete to the best of my (our) knowledge and belief; and will be relied upon in conjunction with the Application to determine my (our) insurability.

I (We) also acknowledge that I (we) have read, or have had read to me, and that I (we) understand 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/Insured Signature	State	Month, Day, Year
_____	_____	_____
Proposed Policy Owner/Owner Signature (if other than Primary Proposed Insured), and title, if applicable	Policy Co-Owner Signature and title, if applicable	
_____	_____	_____
Witness	Insurance Producer	Agent Code

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Flesch Score.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: We are filing an application for this rider for approval.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Approval dates of policies this rider will be attached to.		
Comments:		
Attachment: AR approval dates.pdf		

	Item Status:	Status Date:
Satisfied - Item: Specifications Page		
Comments: We are showing the changes to the Level Term Specifications page, when a Disability Income Rider is added to the policy. A Statement of Variability is attached showing the bracketed information.		
Attachment: Spec page 2002-226 for DIR Sample Redlined.pdf		

	Item Status:	Status Date:
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Date:

Satisfied - Item: Actuarial Memorandum

Comments:

Attachment:

Actuarial Memorandum.pdf

Item Status:

Status

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

STATEMENT OF VARIABILITY.pdf

READABILITY CERTIFICATION

I hereby certify that the forms referenced below have each been scored in their entirety using the Flesch Ease and Reading Test and have attained the score indicated.

I further certify that, to the best of my knowledge and belief, said forms comply with state readability requirements and are printed in not less than ten point type, one point leaded.

The readability score is calculated by computer.

Form:

Flesch Score:

Disability Income Rider

58

Disability Income Rider Application Supplement

64.5

Farmers New World Life Insurance Company
NAIC Number: 0212-63177

A handwritten signature in black ink, appearing to read 'John Patton', followed by a long horizontal line extending to the right.

John Patton, Vice President, Staff Operations

AR	Name	Approval Date
2000-226	Modified Premium Level Term to 90, premiums payable for 30 years	1/25/2001
2000-228	Modified Premium Level Term	12/31/1999
2002-230	Modified Premium Level Term	12/31/1999

Farmers New World Life Insurance Company
Policy Specifications

INSURED	[JOHN A DOE]	ISSUE AGE	[35]	SEX	[M]
POLICY NUMBER	[001234567]	PRINCIPAL SUM			[\$150,000]
ISSUE DATE	[July 1, 2011]	EXPIRY DATE			[July1, 2066]

PREMIUMS

	ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	SPECIAL MONTHLY
PREMIUM PAYMENTS*	[\$678.40]	[\$341.20]	[\$171.61]	[\$60.54]	[\$57.04]
PREMIUM CLASS	[PREFERRED NON-NICOTINE]				

YOU HAVE ELECTED TO PAY ANNUAL PREMIUMS.

ACCELERATED BENEFIT RIDER FOR TERMINAL ILLNESS PROVIDED AT NO ADDITIONAL PREMIUM.

BENEFIT

	ANNUAL PREMIUM	PREMIUMS PAYABLE UNTIL
LEVEL TERM TO AGE 90	[\$419.50*]	AGE 90
¹ DISABILITY INCOME RIDER	[\$258.90***]	AGE 65
² MONTHLY DISABILITY BENEFIT: [\$1,000]		
³ CCUPATIONAL CLASS: [1]		
⁴ ELIMINATION PERIOD: [90 DAYS]		
⁵ MAXIMUM BENEFIT PERIOD: [24 MONTHS]		
⁶ RIDER EFFECTIVE DATE: [July 1, 2011]		
<hr/>		
TOTAL INITIAL PREMIUM*	[\$678.40]	

*THIS PREMIUM IS NOT GUARANTEED AND MAY BE CHANGED BY US ANY TIME AFTER YEAR [30], SUBJECT TO THE GUARANTEED MAXIMUM PREMIUMS. THE PREMIUM WILL INCREASE AFTER YEAR [30]. SEE THE SCHEDULE OF PREMIUMS, SHOWN WITHIN.

⁷*PREMIUMS ARE NOT GUARANTEED AND MAY BE CHANGED BY US ANY TIME AFTER YEAR [2].**

2002-226 NONPARTICIPATING MODIFIED PREMIUM LEVEL TERM LIFE INSURANCE. PREMIUMS GUARANTEED FOR FIRST THIRTY YEARS AFTER ISSUE. PREMIUM SUBJECT TO CHANGE AFTER THE INITIAL LEVEL PREMIUM PERIOD. PREMIUMS PAYABLE TO AGE 90 OR UNTIL PRIOR DEATH. CONVERTIBLE AS DESCRIBED HEREIN.

FARMERS NEW WORLD LIFE INSURANCE
Statement of Variability
July 15, 2011

Variable Item Description:

DISABILITY INCOME RIDER

Bracketed, variable information is found in the Officer Title and Signature on the last page of the Rider.

Officer Title and Signature will vary based on current company operations. In the event the title of an officer signing the policy form changes, any new title utilized will be the title of an officer of the company.

Specification Page.

1. **DISABILITY INCOME RIDER:** [\$XX.XX]: Charge per the mode the owner has selected, annual, semiannual etc.
2. **MONTHLY DISABILITY BENEFIT:** [\$1,000-\$5,000] Benefit \$ amount selected per the application or approved by underwriter.
3. **OCCUPATIONAL CLASS:** [1-3]: Insured's class based on application (occupation).
4. **ELIMINATION PERIOD:** 90 days, but may vary by state.
5. **MAXIMUM BENEFIT PERIOD:** 24 months, but we may change this to a longer period in the future.
6. **RIDER EFFECTIVE DATE:** Issue date of rider, and the same date as the policy issue date.
- 7.*****PREMIUMS ARE NOT GUARANTEED AND MAY BE CHANGED BY US AT ANY TIME AFTER YEAR [2].** We may change the two year period in the future.

Disability Income Rider Application Supplement.

We will update our address if any part of the address block changes.
There are no other bracketed items.