

**State:** Arkansas **Filing Company:** Farmers New World Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2012 Life Applications-Rev  
**Project Name/Number:** 2012 Life Applications-Rev/2012 Life Applications-Rev

## Filing at a Glance

Company: Farmers New World Life Insurance Company  
Product Name: 2012 Life Applications-Rev  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 09/28/2012  
SERFF Tr Num: FNWW-128708047  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 2012 APP FILING-REV  
  
Implementation: On Approval  
Date Requested:  
Author(s): Peter Lindstrom, Sunne Powell, Isaac Liu, Joel Kuni  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 10/03/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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## General Information

Project Name: 2012 Life Applications-Rev Status of Filing in Domicile: Not Filed  
Project Number: 2012 Life Applications-Rev Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 10/03/2012  
State Status Changed: 10/03/2012  
Deemer Date: Created By: Peter Lindstrom  
Submitted By: Peter Lindstrom Corresponding Filing Tracking Number: 2012 Life Applications-Rev

Filing Description:  
September 28, 2012

NAIC NO.: 0212-63177  
Re: Form No.: 31-4633 Annuity Application  
App Part 1-Rpl Application for Life Insurance Part 1  
e-Life App-Rpl e-Life Insurance Application  
51-1546 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, approved in your state. 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. These few changes were made to be in compliance with Arkansas Bulletin 4-2012 concerning replacements. I have enclosed a Red-lined version of each form showing the changes made. These changes are list below:

Our replacement questions have been revised to be closer to the NAIC Replacement Model Regulation. If the second question is answered "Yes", then the Replacement forms 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 indicate your approval of these forms. If you have any questions, please call me at 206-275-8131, fax me at 206-236-

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6526 or email me at peter.lindstrom@farmersinsurance.com.

Sincerely,

Pete Lindstrom  
Contract Specialist

## Company and Contact

### Filing Contact Information

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	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$200.00
Retaliatory?	No
Fee Explanation:	4 forms x \$50.00 = \$200.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
Farmers New World Life Insurance Company	\$200.00	09/28/2012	63213458

SERFF Tracking #:

FNWW-128708047

State Tracking #:

Company Tracking #:

2012 APP FILING-REV

State:

Arkansas

Filing Company:

Farmers New World Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2012 Life Applications-Rev

Project Name/Number:

2012 Life Applications-Rev/2012 Life Applications-Rev

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/03/2012	10/03/2012

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## Disposition

Disposition Date: 10/03/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of variability for all applications		Yes
Supporting Document	red-lined copy of changes made to forms		Yes
Form	Application for Life Insurance Part 1		Yes
Form	e-Life Insurance Application		Yes
Form	Annuity Application		Yes
Form	Application for Life insurance-Amendment C		Yes

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## Form Schedule

Lead Form Number: App Part 1-Rpl							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		App Part 1-Rpl	AEF	Application for Life Insurance Part 1	Revised: Replaced Form #: App Part 1 Previous Filing #: FNWW-128544224	59.870	App Part 1 - Rpl - AR Filing Master rev 9-12.pdf
2		e-Life App-Rpl	AEF	e-Life Insurance Application	Revised: Replaced Form #: e-Life App Previous Filing #: FNWW-128544224	67.690	e-Life App - Rpl - AR Filing Master Rev 9-12.pdf
3		31-4633	AEF	Annuity Application	Revised: Replaced Form #: 31-4492 Previous Filing #: FNWW-126271873	50.140	31-4633 - Annuity Application AR - Master rev 9-12.pdf
4		51-1546	AEF	Application for Life insurance- Amendment C	Revised: Replaced Form #: 51-1272 Previous Filing #: FNWW-126271873	54.400	51-1546 - Amendment C - AR-NAIC - Master rev 9-12.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage

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Company Tracking #:

2012 APP FILING-REV

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<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

# 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*  
*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 N 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 \_\_\_\_\_  Non-Nicotine  
 Face Amount \$ \_\_\_\_\_  Nicotine  
 Accidental Death Benefit \$ \_\_\_\_\_  
 Children's Insurance Rider # of Units: \_\_\_\_\_  
 Other/Additional Insured Insurance Amount  
 \$ \_\_\_\_\_ (FEUL, MPP & PWL only)  
 Accelerated Benefit Rider for Terminal Illness  
 (Complete disclosure form, if applicable)

*Whole Life plans only:*  
 Waiver of Premium (adult policy only)  
 Guaranteed Insurability Benefit  
 \$ \_\_\_\_\_ (juvenile policy only)  
*nonforfeiture options:*  
 Automatic Premium Loan  
 Extended Term Insurance  
 Reduced Paid-Up Insurance

*Premier Whole Life only:*  
 Payor Benefits (juvenile policy only)  
 Excess Credit Option  
 Cash  
 Paid-Up Additions  
 Premium/Retirement Deposit Fund  
 Reduced Premium  
 Single Premium Rider \$ \_\_\_\_\_  
 One-Year Term Rider \$ \_\_\_\_\_

*Farmers Value Term plans only:*

*Nicotine:*  Gold  Gold Plus      *Non-Nicotine:*  Platinum  Platinum Choice  Platinum Plus  Platinum Elite

*(Can select no more than one of the following) (adult policy only):*

*(20 and 30 year plans only):*

Waiver of Premium  
 Disability Income Rider \$ \_\_\_\_\_  
 (Complete Application Supplement)

Critical Illness Accelerated Benefit Rider  
 \$ \_\_\_\_\_ Benefit Amount  
 (Complete disclosure form and Application Supplement)

*Universal Life plans only:*

Standard Non-Nicotine  Standard Nicotine  Standard Juvenile  Preferred Non-Nicotine  Premier Non-Nicotine

Death Benefit Option (choose one):

*(Can select no more than one of the following):*

Increasing/Variable (A) or  Level (B)

Waiver of Deduction (adult policy only)

Automatic Increase Benefit

Owner Waiver of Deduction (FEUL juvenile policy only)

Monthly Disability Benefit \$ \_\_\_\_\_ per month (adult policy only)

**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:**

Bank Check Plan *monthly deduction*  
 (Complete a Bank Authorization form)       Folio/Agent Payroll Deduction       Direct Bill (select desired frequency)  
 Government Allotment       FIG/Farmers Employee Deduction       Annual       Semi-Annual  
 Other \_\_\_\_\_       Monthly       Quarterly

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

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

**G. Other Insurance In Force and Replacement**

Complete for all Proposed Insured(s). (Use "Other Remarks" in section O, 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?

Yes  No

Yes  No

If "Yes," 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

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," complete 1035 Exchange forms.

Yes  No



L. Supplementary Information <i>(Use appropriate "Additional Details" space in section O, 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

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

**N. 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: \_\_\_\_\_

**O. 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 Acknowledgement**

I (We), the Proposed Owner(s), understand and agree that no insurance coverage is in force as a result of this Application for insurance until the policy applied for has been issued, and the first full modal premium has been paid. If the policy is issued other than applied for, no coverage is in effect until the policy is issued, delivered and accepted, and the first full modal premium has been paid. If a request to backdate the policy has been made, no coverage is in effect until the policy is issued and delivered during the lifetime of the Proposed Insured(s) and the first full modal premium has been paid. "Policy" as used herein shall mean a policy issued and in effect as a result of this Application whether issued as applied for or otherwise. I (We) understand that I (we) have the right to purchase Temporary Insurance that, if I (we) meet all eligibility requirements, will provide a limited amount of coverage from the time the Temporary Insurance Application and Agreement (TIAA) is signed until the Policy takes effect. The terms and conditions for Temporary Insurance, including eligibility, coverage, duration and termination are described on the TIAA attached to and bearing the same application number as this Application. If I (we) am eligible and choose to purchase Temporary Insurance, I (we) understand that the first full modal premium payment collected is for Temporary Insurance and that the entire premium payment will be applied to the Policy if and when it takes effect. If I (we) am not eligible or choose not to purchase Temporary Insurance, no agent of Farmers New World Life Insurance Company (FNWL) is allowed to accept a premium payment in connection with this Application or an application for Temporary Insurance and no coverage of any kind is in force by virtue of this Application. In the event of multiple pending applications on a Proposed Insured or Additional Proposed Insured, the maximum amount of Temporary Insurance coverage payable by FNWL is **500,000** on any one life, subject to the terms of the Temporary Insurance Agreement described on the TIAA and regardless of the number of Temporary Insurance Agreements.

**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 (MIB); 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. Furthermore, I (we) authorize FNWL, or its reinsurers, to make a brief report of my (our) personal health information to MIB. 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 Immune Deficiency 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 at \_\_\_\_\_ on \_\_\_\_\_  
Month, Day, Year

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

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

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

# Farmers New World Life Insurance Company

Merger Island Life Office: 3003 77<sup>th</sup> Ave. S.E., Merger 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

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 Policy Number: **EA**

## e-Life Insurance Application

### A. Primary Proposed Insured

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 (if other than English)
--------------------------	----------------------------	---

Parent Name (If a juvenile policy) \_\_\_\_\_

### B. Proposed Policy Owner Completed only when other than Primary Proposed Insured. (Trust Ownership, Policy Co-Owner and Successor Policy Owner information is in section H.)

Name of Proposed Policy Owner \_\_\_\_\_

Primary Telephone Number	Secondary Telephone Number	Primary Language Spoken (if other than English)
--------------------------	----------------------------	---

Relationship to Primary Proposed Insured  Business  Spouse  Parent  Other \_\_\_\_\_

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Place of Birth	Taxpayer ID Number or SSN
---	---------------	----------------	---------------------------

Address \_\_\_\_\_

### C. 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 \$ \_\_\_\_\_  
 Standard  Preferred  Premier  
 Non-nicotine  Nicotine  Juvenile  
 Accidental Death Benefit \$ \_\_\_\_\_  
 Guaranteed Insurability Benefit  
 \$ \_\_\_\_\_ (juvenile policy only)  
 Waiver of Premium (adult policy only)  
 Payor/Owner Benefits (juvenile policy only)  
 Children's Insurance Rider \_\_\_\_\_ units  
 Accelerated Benefit Rider for Terminal Illness

*Whole Life plans only - nonforfeiture options:*

- Automatic Premium Loan
- Extended Term Insurance
- Reduced Paid-Up Insurance

*Premier Whole Life only:*

- Excess Credit Option
- Cash
- Paid-Up Additions
- Premium/Retirement Deposit Fund
- Reduced Premium

Single Premium Rider \$ \_\_\_\_\_

One-Year Term Rider \$ \_\_\_\_\_

*Universal Life plans only:*

Death Benefit Option (choose one)

- Increasing/Variable (A)
- Level (B)

Automatic Increase Benefit

(select no more than one of the following)

- Waiver of Deduction
- Monthly Disability Benefit

\$ \_\_\_\_\_ per month

*Level Term 2000 (20 and 30 year) only:*

- Critical Illness Accelerated Benefit Rider
- \$ \_\_\_\_\_ Benefit Amount

### D. Sales Illustration

Has the Proposed Policy Owner been provided a written illustration that conforms to this Application for life insurance coverage?

Yes  No

**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 \_\_\_\_\_
- 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 I.)

Is there any life insurance or annuity in-force or application pending on the life of any Proposed Insured?  Yes  No  
(Details listed 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? (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. 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)

**H. 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: \_\_\_\_\_

**I. 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 Acknowledgement**

I (We), the Proposed Owner(s), understand and agree that no insurance coverage is in force as a result of this Application for insurance until the policy applied for has been issued, and the first full modal premium has been paid. If the policy is issued other than applied for, no coverage is in effect until the policy is issued, delivered and accepted, and the first full modal premium has been paid. If a request to backdate the policy has been made, no coverage is in effect until the policy is issued and delivered during the lifetime of the Proposed Insured(s) and the first full modal premium has been paid. "Policy" as used herein shall mean a policy issued and in effect as a result of this Application whether issued as applied for or otherwise. I (We) understand that I (we) have the right to purchase Temporary Insurance that, if I (we) meet all eligibility requirements, will provide a limited amount of coverage from the time the Temporary Insurance Application and Agreement (TIAA) is signed until the Policy takes effect. The terms and conditions for Temporary Insurance, including eligibility, coverage, duration and termination are described on the TIAA attached to and bearing the same application number as this Application. If I (we) am eligible and choose to purchase Temporary Insurance, I (we) understand that the first full modal premium payment collected is for Temporary Insurance and that the entire premium payment will be applied to the Policy if and when it takes effect. If I (we) am not eligible or choose not to purchase Temporary Insurance, no agent of Farmers New World Life Insurance Company (FNWL) is allowed to accept a premium payment in connection with this Application or an application for Temporary Insurance and no coverage of any kind is in force by virtue of this Application. In the event of multiple pending applications on a Proposed Insured or Additional Proposed Insured, the maximum amount of Temporary Insurance coverage payable by FNWL is **(\$500,000)** on any one life, subject to the terms of the Temporary Insurance Agreement described on the TIAA and regardless of the number of Temporary Insurance Agreements.

**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 (MIB); 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. **Furthermore, I (we) authorize FNWL, or its reinsurers, to make a brief report of my (our) personal health information to MIB.** 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 Immune Deficiency 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		Month, Day, Year
<b>Primary Proposed Insured Signature</b> (or parent if Primary Proposed Insured is a juvenile)		State			
	Signed at		on		Month, Day, Year
<b>Proposed Policy Owner Signature</b> (if other than Primary Proposed Insured), and title, if applicable		State			
	<b>Proposed Owner's Spouse Signature</b> (where required in community property states when a person other than Policy Owner's spouse is named as Primary Beneficiary)		<b>Policy Co-Owner Signature</b> 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.*

<b>Agent Name</b> (please print or type)	<b>Agent/Representative Code Number</b>	<b>Agent Signature</b>	<b>Date</b>

# 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

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.)				Gender	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.					
Does the Proposed Annuitant have any life insurance or annuity in-force or application pending? .....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 "Yes," complete required replacement form(s).).....Proposed Annuitant Response: <input type="checkbox"/> Yes <input type="checkbox"/> No					
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:

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 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).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding. ....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) The IRS has notified me that I am no longer subject to backup withholding. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I am a U.S. person (including a U.S. resident alien). ....  | <input type="checkbox"/> | <input type="checkbox"/> |

**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).

I also acknowledge that I have read the fraud warning and/or other 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 \_\_\_\_\_ on \_\_\_\_\_  
at City, State Month, Day, Year

Proposed Annuitant Signature (or parent if Proposed Annuitant is a juvenile)

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?  
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 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

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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 <i>(Use "Additional Details" in section F, if necessary.)</i>						
Is there any life insurance or annuity 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," 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>						
<i>If "Yes," complete required replacement form(s) and provide details below.</i>						
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? <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:						



**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2012 Life Applications-Rev  
**Project Name/Number:** 2012 Life Applications-Rev/2012 Life Applications-Rev

**Filing Company:** Farmers New World Life Insurance Company

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Application Flesch Score .pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Each application will replace previously approved forms: App Part 1-AR replaces APP Part 1 approved 7/13/2012 e-Life App-AR replaces e-Life App approved 7/13/2012 31-4633 replaces 31-4492 approved 8/21/2009 51-1546 replaces 51-1272 approved 8/21/2009  (See the Form Schedule)		

		Item Status:	Status Date:
Satisfied - Item:	Statement of variability for all applications		
Comments:	I have attached a Statement of Variability for the applications included in this filing		
Attachment(s):			
Farmers Statement of Variability.pdf			

		Item Status:	Status Date:
Satisfied - Item:	red-lined copy of changes made to forms		
Comments:			
Attachment(s):			

**SERFF Tracking #:**

FNWW-128708047

**State Tracking #:**

**Company Tracking #:**

2012 APP FILING-REV

**State:**

Arkansas

**Filing Company:**

Farmers New World Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

2012 Life Applications-Rev

**Project Name/Number:**

2012 Life Applications-Rev/2012 Life Applications-Rev

App Part 1 - Rpl - AR Redlined rev 9-12.pdf

e-Life App - Rpl - AR Redlined Rev 9-12.pdf

31-4633 - Annuity Application AR - Redlined rev 9-12.pdf

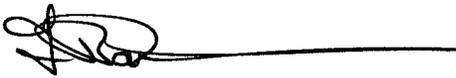
51-1546 - Amendment C - AR-NAIC - Redlined rev 9-12.pdf

Farmers New World Life Insurance Company  
Certificate of Readability

The undersigned certifies that the attached forms have a Flesch score as follows:

<u>Form #</u>	<u>Flesch Score</u>
e-Life App -Rpl	67.69
31-4633	50.14
51-1546	54.4
App Part 1 -Rpl	59.87

By:

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

Name: John Patton  
Its: Vice President of Staff Operations

September 28, 2012

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.

The above information is standard variable information on all our applications being filed.

The following information is Variable each form listed:

**Form App Part 1-AR- Application for Life Insurance Part 1-**

**Section D-** 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. All products listed will be filed and approved by the state. We will be refiling and replacing some products due to the 2001 CSO tables.

**Taxpayer Certification section-** This section is bracketed for changes required by the IRS in the event that their language is revised.

**MIB address and Authorization-** the address and phone number are bracketed for changes to the MIB information. We have bracketed the MIB Authorization so if changes are made in this statement as required by MIB that we will not need to re-file.

The amount of \$500,000 will be bracketed in each application and the Temporary Insurance Agreement coverage portion of each application is bracketed so that the Temporary Insurance limits may be changed in the future without requiring an application re-file. The parameters for the amount is between \$50,000 and \$1,000,000.

**Form E-Life App-AR- E-Life Insurance Application**

**- Section C -** 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. All products listed will be filed and approved by the state. We will be refiling and replacing some products due to the 2001 CSO tables.

**Taxpayer Certification section-** This section is bracketed for changes required by the IRS in the event that their language is revised.

**MIB address and Authorization-** the address and phone number are bracketed for changes to the MIB information. We have bracketed the MIB Authorization so if changes are made in this statement as required by MIB that we will not need to re-file.

The amount of \$500,000 will be bracketed in each application and the Temporary Insurance Agreement coverage portion of each application is bracketed so that the Temporary Insurance limits may be changed in the future without requiring an application re-file. The parameters for the amount is between \$50,000 and \$1,000,000.

# 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*

*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 N 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 \_\_\_\_\_  Non-Nicotine  
 Face Amount \$ \_\_\_\_\_  Nicotine  
 Accidental Death Benefit \$ \_\_\_\_\_  
 Children's Insurance Rider # of Units: \_\_\_\_\_  
 Other/Additional Insured Insurance Amount  
 \$ \_\_\_\_\_ (FEUL, MPP & PWL only)  
 Accelerated Benefit Rider for Terminal Illness  
 (Complete disclosure form, if applicable)

*Whole Life plans only:*  
 Waiver of Premium (adult policy only)  
 Guaranteed Insurability Benefit  
 \$ \_\_\_\_\_ (juvenile policy only)  
*nonforfeiture options:*  
 Automatic Premium Loan  
 Extended Term Insurance  
 Reduced Paid-Up Insurance

*Premier Whole Life only:*  
 Payor Benefits (juvenile policy only)  
 Excess Credit Option  
 Cash  
 Paid-Up Additions  
 Premium/Retirement Deposit Fund  
 Reduced Premium  
 Single Premium Rider \$ \_\_\_\_\_  
 One-Year Term Rider \$ \_\_\_\_\_

*Farmers Value Term plans only:*

*Nicotine:*  Gold  Gold Plus      *Non-Nicotine:*  Platinum  Platinum Choice  Platinum Plus  Platinum Elite

*(Can select no more than one of the following) (adult policy only):*

*(20 and 30 year plans only):*

Waiver of Premium  
 Disability Income Rider \$ \_\_\_\_\_  
 (Complete Application Supplement)

Critical Illness Accelerated Benefit Rider  
 \$ \_\_\_\_\_ Benefit Amount  
 (Complete disclosure form and Application Supplement)

*Universal Life plans only:*

Standard Non-Nicotine  Standard Nicotine  Standard Juvenile  Preferred Non-Nicotine  Premier Non-Nicotine

Death Benefit Option (choose one):

*(Can select no more than one of the following):*

Increasing/Variable (A) or  Level (B)

Waiver of Deduction (adult policy only)

Automatic Increase Benefit

Owner Waiver of Deduction (FEUL juvenile policy only)  
 Monthly Disability Benefit \$ \_\_\_\_\_ per month (adult policy only)

**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:**

Bank Check Plan *monthly deduction* (Complete a Bank Authorization form)       ~~Farmers EasyPay number~~ \_\_\_\_\_  Direct Bill (select desired frequency)  
 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 \$ \_\_\_\_\_

**G. Other Insurance In Force and Replacement**

Complete for all Proposed Insured(s). (Use "Other Remarks" in section O, 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?

Yes  No

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

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," complete 1035 Exchange forms.*

Yes  No



L. Supplementary Information <i>(Use appropriate "Additional Details" space in section O, 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

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

**N. 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: \_\_\_\_\_

**O. 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 Acknowledgement**

I (We), the Proposed Owner(s), understand and agree that no insurance coverage is in force as a result of this Application for insurance until the policy applied for has been issued, and the first full modal premium has been paid. If the policy is issued other than applied for, no coverage is in effect until the policy is issued, delivered and accepted, and the first full modal premium has been paid. If a request to backdate the policy has been made, no coverage is in effect until the policy is issued and delivered during the lifetime of the Proposed Insured(s) and the first full modal premium has been paid. "Policy" as used herein shall mean a policy issued and in effect as a result of this Application whether issued as applied for or otherwise. I (We) understand that I (we) have the right to purchase Temporary Insurance that, if I (we) meet all eligibility requirements, will provide a limited amount of coverage from the time the Temporary Insurance Application and Agreement (TIAA) is signed until the Policy takes effect. The terms and conditions for Temporary Insurance, including eligibility, coverage, duration and termination are described on the TIAA attached to and bearing the same application number as this Application. If I (we) am eligible and choose to purchase Temporary Insurance, I (we) understand that the first full modal premium payment collected is for Temporary Insurance and that the entire premium payment will be applied to the Policy if and when it takes effect. If I (we) am not eligible or choose not to purchase Temporary Insurance, no agent of Farmers New World Life Insurance Company (FNWL) is allowed to accept a premium payment in connection with this Application or an application for Temporary Insurance and no coverage of any kind is in force by virtue of this Application. In the event of multiple pending applications on a Proposed Insured or Additional Proposed Insured, the maximum amount of Temporary Insurance coverage payable by FNWL is **{ \$500,000 }** on any one life, subject to the terms of the Temporary Insurance Agreement described on the TIAA and regardless of the number of Temporary Insurance Agreements.

**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 (MIB); 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. **{ Furthermore, I (we) authorize FNWL, or its reinsurers, to make a brief report of my (our) personal health information to MIB. }** 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 Immune Deficiency 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 at \_\_\_\_\_ on \_\_\_\_\_  
Month, Day, Year

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

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

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

# Farmers New World Life Insurance Company

Merger Island Life Office: 3003 77<sup>th</sup> Ave. S.E., Merger 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

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



**FARMERS**  
LIFE INSURANCE

Application Policy Number: **EA**

## e-Life Insurance Application

### A. Primary Proposed Insured

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 (if other than English)	
Parent Name (If a juvenile policy)			

### B. Proposed Policy Owner Completed only when other than Primary Proposed Insured. (Trust Ownership, Policy Co-Owner and Successor Policy Owner information is in section H.)

Name of Proposed Policy Owner			
Primary Telephone Number	Secondary Telephone Number	Primary Language Spoken (if other than English)	
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			

### C. 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) Children's Insurance Rider _____ units <input type="checkbox"/> Accelerated Benefit Rider for Terminal Illness	<b>Whole Life plans only - nonforfeiture options:</b> <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-Up Insurance  <b>Premier Whole Life only:</b> 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 \$ _____	<b>Universal Life plans only:</b> 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  <b>Level Term 2000 (20 and 30 year) only:</b> <input type="checkbox"/> Critical Illness Accelerated Benefit Rider \$ _____ Benefit Amount
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### D. Sales Illustration

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

**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
- ~~Farmer's EasyPay number~~ \_\_\_\_\_
- Government Allotment
- Folio/Agent Payroll Deduction
- Other \_\_\_\_\_
- 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 I.)

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. 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)

**H. 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: \_\_\_\_\_

**I. 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 Acknowledgement**

I (We), the Proposed Owner(s), understand and agree that no insurance coverage is in force as a result of this Application for insurance until the policy applied for has been issued, and the first full modal premium has been paid. If the policy is issued other than applied for, no coverage is in effect until the policy is issued, delivered and accepted, and the first full modal premium has been paid. If a request to backdate the policy has been made, no coverage is in effect until the policy is issued and delivered during the lifetime of the Proposed Insured(s) and the first full modal premium has been paid. "Policy" as used herein shall mean a policy issued and in effect as a result of this Application whether issued as applied for or otherwise. I (We) understand that I (we) have the right to purchase Temporary Insurance that, if I (we) meet all eligibility requirements, will provide a limited amount of coverage from the time the Temporary Insurance Application and Agreement (TIAA) is signed until the Policy takes effect. The terms and conditions for Temporary Insurance, including eligibility, coverage, duration and termination are described on the TIAA attached to and bearing the same application number as this Application. If I (we) am eligible and choose to purchase Temporary Insurance, I (we) understand that the first full modal premium payment collected is for Temporary Insurance and that the entire premium payment will be applied to the Policy if and when it takes effect. If I (we) am not eligible or choose not to purchase Temporary Insurance, no agent of Farmers New World Life Insurance Company (FNWL) is allowed to accept a premium payment in connection with this Application or an application for Temporary Insurance and no coverage of any kind is in force by virtue of this Application. In the event of multiple pending applications on a Proposed Insured or Additional Proposed Insured, the maximum amount of Temporary Insurance coverage payable by FNWL is **(\$500,000)** on any one life, subject to the terms of the Temporary Insurance Agreement described on the TIAA and regardless of the number of Temporary Insurance Agreements.

**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 (MIB); 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. **Furthermore, I (we) authorize FNWL, or its reinsurers, to make a brief report of my (our) personal health information to MIB.** 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 Immune Deficiency 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)

Signed \_\_\_\_\_ at \_\_\_\_\_ on \_\_\_\_\_

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

**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 Name (please print or type) \_\_\_\_\_ Agent/Representative Code Number \_\_\_\_\_ Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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*

*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

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

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.)				Gender	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	
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.					
Does the Proposed Annuitant have any life insurance or annuity in-force or application pending? (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 "Yes," complete required replacement form(s)).....Proposed Annuitant Response: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Remarks/Instructions:					

### Acknowledgement and Declaration

1. 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.
2. 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).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding. ....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) The IRS has notified me that I am no longer subject to backup withholding. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I am a U.S. person (including a U.S. resident alien). ....  | <input type="checkbox"/> | <input type="checkbox"/> |

**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). I also acknowledge that I have read the fraud warning and/or other 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 \_\_\_\_\_ on \_\_\_\_\_  
at City, State Month, Day, Year

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

\_\_\_\_\_  
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 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

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 \_\_\_\_\_