

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
Project Name/Number: 2012 Life Applications/2012 Life Applications

Filing at a Glance

Company: Farmers New World Life Insurance Company
Product Name: 2012 Life Applications
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 07/11/2012
SERFF Tr Num: FNWW-128544224
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 2012 APPLICATION FILING

Implementation: On Approval
Date Requested:
Author(s): Peter Lindstrom, Sunne Powell, Natalie Volz, Isaac Liu, Joel Kuni
Reviewer(s): Linda Bird (primary)
Disposition Date: 07/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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
Project Name/Number: 2012 Life Applications/2012 Life Applications

General Information

Project Name: 2012 Life Applications Status of Filing in Domicile: Pending
Project Number: 2012 Life Applications Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: We have filed these forms in Washington for approval. Approval is pending.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 07/13/2012
State Status Changed: 07/13/2012
Deemer Date: Created By: Peter Lindstrom
Submitted By: Peter Lindstrom Corresponding Filing Tracking Number: 2012 Life Applications

Filing Description:
NAIC NO.: 0212-63177
Re: Form No.: e-Life e-Life Insurance Application
Simple App Simple Application for Life Insurance
App Part 1 Application for Life Insurance Part 1
PolChg-Rein App Policy Change/Reinstatement Application

Dear Sir or Madam:
We are submitting copies of the above referenced forms for your approval. We have made changes to previously approved forms due to the requirements of MIB. We have added the required wording to our Authorization section: "Furthermore, I authorize FNWL, or its reinsurers, to make a brief report of my personal health information to MIB." The only changes to our previously approved forms are shown in red-lined versions which are also provided, and no other changes are made to our previously approved forms. 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. We will be using these applications with all our approved fixed and variable life plans.
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 forms and previous filings.
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. These forms will be used by licensed representatives who are appointed with the company and may sell through our agency distribution systems.
In addition to the policy forms, this filing packet contains the required certifications and filing fees, if any. Washington, our state of domicile has no filing fee. To the best of our knowledge, these forms comply with the laws of your state and department. Please provide your approval of these forms. If you have any questions, please call me at 206-275-8131, 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

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
 Project Name/Number: 2012 Life Applications/2012 Life Applications

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	07/11/2012	60794843

SERFF Tracking #:	FNWW-128544224	State Tracking #:		Company Tracking #:	2012 APPLICATION FILING
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				
Project Name/Number:	2012 Life Applications/2012 Life Applications				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/13/2012	07/13/2012

SERFF Tracking #:	FNWW-128544224	State Tracking #:	Company Tracking #:	2012 APPLICATION FILING
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			
Project Name/Number:	2012 Life Applications/2012 Life Applications			

Disposition

Disposition Date: 07/13/2012

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	e-Life insurance Application		Yes
Form	Simple Application for Life Insurance		Yes
Form	Application for life Insurance part 1		Yes
Form	Policy Change/Reinstatement Application		Yes

State: Arkansas Filing Company: Farmers New World Life Insurance Company
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Form Schedule

Lead Form Number: e-Life App							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		e-Life App	AEF	e-Life insurance Application	Revised: Replaced Form #: 31-5167 Previous Filing #: FNWW-126993655	67.690	e-Life App - Gen NAIC - Filing Master 31-5167 - MIB Rev 7-12.pdf
2		Simple App	AEF	Simple Application for Life Insurance	Revised: Replaced Form #: 31-4472 Previous Filing #:	58.160	Simple App - Gen - Filing Master 31-4472 - MIB Rev 7-12.pdf
3		App Part 1	AEF	Application for life Insurance part 1	Revised: Replaced Form #: 31-5153 Previous Filing #: FNWW-126993655	59.870	App Part 1 - Gen NAIC - Filing Master 31-5153 - MIB Rev 7-12.pdf
4		PolChg-Rein App	AEF	Policy Change/Reinstatement Application	Revised: Replaced Form #: 31-4451 Previous Filing #:	61.630	PolChg-Rein App - Gen - Filing Master 31-4451 - MIB Rev 7-12.pdf

Form Type Legend:

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

SERFF Tracking #: FNWW-128544224 **State Tracking #:** **Company Tracking #:** 2012 APPLICATION FILING

State: Arkansas **Filing Company:** Farmers New World Life Insurance Company
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POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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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)
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Driver License Number	License Issue State
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Residence Address _____

Billing Address _____

Primary Telephone Number	Secondary Telephone Number	Primary Language Spoken (if other than English)
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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)
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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
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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 _____
- Farmers EasyPay number _____
- Folio/Agent Payroll Deduction
- FIG/Farmers Employee Deduction
- Direct Bill
- Annual
- Monthly
- Semi-Annual
- Quarterly

Universal Life Plans: Planned Premium \$ _____ Lump Sum Payment \$ _____

Premium/Retirement Deposit Fund: Initial Payment \$ _____ Regular Payment \$ _____

F. Other Insurance In Force and Replacement Completed for all Proposed Insured(s). (Overflow of details appears in section 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 <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 _____
at State Month, Day, Year

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

Signed _____ at _____ on _____
at State Month, Day, Year

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 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

Important Notice

Leave this Disclosure Statement with the Primary Proposed Insured

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

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com. }

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

Farmers New World Life Insurance Company

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



FARMERS
LIFE INSURANCE

Simple Application for Life Insurance

A. Proposed Insured Information

Name of Proposed Insured: _____ Date of Birth: _____
Social Security Number (SSN): _____ Gender: _____ Height: _____ Weight: _____
Residence Address: _____ Place of Birth: _____
Telephone Numbers: Primary: _____ Secondary: _____ Occupation: _____
Are you a U.S. Citizen or do you have a Green Card? _____ Green Card Alien Registration Number: _____
Is the Proposed Insured the Policy Owner? _____

B. Driver License Information

Issue State: _____ License Number: _____
1. Have you, in the past five years, pled guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless/careless driving; or in the past three years, had three or more moving violations, or had your driver's license suspended, revoked, cancelled or withdrawn?

C. Proposed Policy Owner Information

Name of Proposed Policy Owner: _____ Date of Birth: _____
Relationship to Proposed Insured: _____ Tax Payer ID Number or SSN: _____ Gender: _____

D. Product Information: Plan, Class, Face Amount and Benefits

Plan: _____ Class: _____ Face Amount: _____ Single Premium: _____
Benefits: _____

E. Sales Illustration

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

F. Billing and Payment Information: Refer to Bank Authorization form

Billing Method: _____ Payment submitted with application: _____
Billing Address: _____

G. Temporary Insurance Eligibility Question

In the past two years, has the Proposed Insured received any treatment or medication for, or been diagnosed as having any kind of cancer or tumor, stroke, drug or alcohol dependency, or any disease or disorder of the heart, liver or kidney?

H. Beneficiary Information

Primary/Contingent	Beneficiary Name(s),	Share %,	Date of Birth	Relationship to Proposed Insured
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Include delay clause? _____ Number of days: _____

I. Other Insurance and/or Pending Application(s) for Life Insurance

Is there any life insurance or annuity in force or application pending on the life of the Proposed Insured?

Will any in-force life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance requested is issued?

Details:

Company	Insured	Policy Number	Life Amount	ADB Amount	Pending?	In-Force?	Replacing?
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Is the insurance applied for intended to be a 1035 Exchange?

J. Owner Benefit Information

Proposed Policy Owner's Height:

Proposed Policy Owner's Weight:

1. Have you, the Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having, appendicitis, any kind of cancer or tumor, diabetes, drug or alcohol dependency, gastric reflux, hernia, pneumonia, pregnancy, stroke, or disability, including receiving disability income benefits; or have you ever had any disease or disorder of the heart, immune system, kidney, liver, or lungs?

K. Children's Insurance Rider Information

Child Name	Gender	Relationship to Proposed Insured	Date of Birth	SSN	Height	Weight	Eligibility
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1. Has any child ever had, or been treated or hospitalized for, appendicitis, asthma, cancer, congenital or birth disorder, diabetes, heart disorder, hernia, leukemia, premature birth, RSV(Respiratory Syncytial Virus), scoliosis, seizures, tonsillectomy, tubes in ears, tumor, or any other disease or disorder?

L. Juvenile Plan Information

1. Amount of life insurance on:
Mother: _____ Father: _____ Household Income: _____
2. Do both parents have at least as much insurance in force or applied for as the Proposed Insured?
3. Amount of life insurance on each child:
4. Do all children in household have at least as much insurance in force or applied for as the Proposed Insured?

M. Medical and Supplemental Information Regarding the Proposed Insured

1. Have you, in the past three years, participated in or do you plan to participate in any of the following activities: aeronautics, including ballooning, hang gliding, parachuting, or skydiving; racing, including boat, car, or motorcycle; scuba diving; hiking, including mountain climbing or rock climbing; or any similar hazardous activities?
2. Do you anticipate residence or travel, including military deployment, outside the United States during the next two years (excluding travel as a pilot or crew member of a commercial flight)?
3. Do you anticipate the total number of days of travel or residence, including military deployment, outside the United States during the next two years to exceed 90 days (excluding travel as a pilot or crew member of a commercial flight)?
4. Have you, in the past three years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline flight?
5. Have you, in the past seven years, had, consulted a physician or other healthcare provider(s) for, or been treated or hospitalized for or taken medication for any of the following: any diseases or disorders of the heart (including rheumatic fever), circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs (including allergies or sleep apnea); any mental or nervous disorders (including depression, anxiety, or suicide); muscular, spinal, joint, or bone disorders or injuries (including concussions); high blood pressure; elevated cholesterol; cancer/skin cancer; stroke; epilepsy/seizures (including dizziness or fainting); arthritis; congenital defects or physical impairments?

6. Have you ever been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder, or have you tested positive for HIV antibodies or antigens?
7. Have you, in the past 12 months, been hospitalized for 24 or more consecutive hours?
8. Have you scheduled or been advised to have, a surgical operation, diagnostic test, or evaluation that has not been completed?
9. Have you, in the past 12 months, used Tobacco or Nicotine products in any form?
10. Have you, in the past 10 years, used illegal drugs, or consulted a healthcare provider or treatment facility for abuse of alcohol or drugs (including prescription drugs)?
11. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, been incarcerated for a felony offense, or been placed on probation or parole for a felony offense, or are felony charges currently outstanding against you?
12. Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities?
13. Have you, within the past 12 months, been confined to, or been advised to use the services of any of the following: adult day care facility, assisted living facility, home health care services, nursing home, or residential care facility?
14. Do you require the assistance or supervision of another person or device of any kind for any of the following: getting in or out of a bed or chair; self-care, such as eating, dressing, bathing and/or using the bathroom; or walking, such as need for a walker, wheelchair or scooter?
15. Do you require the assistance or supervision of another person to perform any of the following: doing laundry, making financial or banking decisions, housekeeping, making telephone calls, preparing meals, shopping, or taking medication?
16. Have you seen a physician within the past two years?
17. Have you, in the past six months, experienced an unintentional or unexplained weight loss, not due to increase in exercise or intentional change in diet?
18. Do you participate in activities outside the home?
19. Have you had two or more falls in the past 12 months?

Additional Information

Certification, Authorization and Acknowledgement Signatures

Temporary Insurance Agreement (TIA) Coverage

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

Illustration

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

Taxpayer Certification

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

- 1. The Social Security Number shown on this form is my correct taxpayer identification number (TIN) (or I am waiting for a number to be issued to me), **and**
- 2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(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, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
- 3. I am a U.S. person (including a U.S. resident alien).

{Certification 2 above does not apply to me (us).}

Authorization to Obtain and Disclose Information

I (We) understand that non-medical and medical information ("Personal Information") will be used by Farmers New World Life Insurance Company (FNWL) to determine my and/or the minor child's eligibility for the insurance coverage applied for in this Application as well as to determine eligibility and evaluate claims for benefits under any policy issued in connection with this Application. Personal Information includes, but is not limited to information about me and/or the minor child regarding: mental and physical health, including information about medical care, treatment, advice, alcohol and nicotine use, drug use, prescription drug history, as well as communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; motor vehicle, financial, and criminal records; hazardous activities; and avocations.

By signing this Application, I (we) authorize licensed physicians; medical practitioners; hospitals; clinics or other medical or medically-related facilities; insurance companies; the Medical Information Bureau (MIB); the Veterans Administration; the Social Security Administration; and consumer reporting agencies to release Personal Information to FNWL, its reinsurers, and their legal representatives. Furthermore, I (we) authorize FNWL, or its reinsurers, to make a brief report of my (our) personal health information to MIB. A copy of this authorization shall be as valid as the original. This authorization is valid for 24 months from the date of this Application. I (We), as well as any person authorized to act on my (our) behalf, may, upon written request, obtain a copy of this authorization. I (We), as well as any person authorized to act on my (our) behalf, may revoke this authorization at any time by sending written notice to FNWL. Changing, revoking or failing to sign this authorization will impair processing of the Application; as a result, the Application may be denied.

I (We) understand that some or all of the data collected to create this Application, including any electronic or voice signature, may be transmitted and/or maintained by FNWL in electronic format. I (we) understand that my (our) electronic or voice signature(s) printed/indicated on this Application as shown below is my (our) consent to complete this Application by electronic means. A paper copy of this Application with my (our) electronic or voice signature(s) printed/indicated on the paper Application will be provided to me (us) with the Policy Contract, if issued, or upon receipt by FNWL of my (our) written request. My (our) electronic or voice signature(s) will not be attached to or used for any other transaction unless I (we) provide my (our) consent, which would be indicated with new electronic or voice signature(s) for the separate transaction.

Acknowledgement

I (We) have read, or have had read to me (us), the Important Notice disclosure statement listed on Form 31-5287 given to me (us) on this date. I (We) acknowledge that this Application signed by me (us), will become a part of the policy if issued by FNWL. I (We) also acknowledge that I (we) have read, or have had read to me (us), and that I (we) understand the fraud warning and/or other notice listed on Form 31-4226 for my (our) state of residence, if any. I (We) have read and reviewed the above statements and the answers to the questions on this Application and hereby represent that such statements and answers are true and complete to the best of my (our) knowledge and belief. **Except as stated in the Temporary Insurance Agreement (if any) provided upon payment of premium, I (We) understand and acknowledge that no policy will be issued and no insurance coverage is in force unless: (a) this Application, along with any additional applications, addendums, amendments, questionnaires, and medical examination forms have been completed and signed by me (us) and received by the Company, (b) the full first modal premium has been paid, and (c) the Application has been approved by FNWL without modification. In the event FNWL approves the Application other than as applied for ("with modification"), no policy will be issued and no coverage will be in force until I (we) have also accepted in writing the policy as modified. I (We) understand and agree that no agent is authorized to: (a) make or modify contracts, (b) waive any of FNWL's rights or requirements, or (c) accept risks or make any determination as to insurability.**

Signature of Proposed Insured	Signed in	State	on	Date/Time stamp
Signature of Proposed Policy Owner (if other than the Proposed Insured)	Signed in	State	on	Date/Time stamp
Signature of Policy Owner's Spouse <small>(where required in community property states)</small>	Signed in	State	on	Date/Time stamp

I certify that I have truly and accurately recorded on this Application the information given by the Proposed Insured and Policy Owner(s)/Spouse, verified their identity(ies) and witnessed their signature(s). To the best of your knowledge, is there any life insurance or annuity in-force, or application pending on the life of the Proposed Insured? Yes No. To the best of your knowledge, will the life insurance applied for replace or reduce current coverage with this or any other company? Yes No. If a replacement, was sales material used in the solicitation? Yes No. *Copies of the materials must be submitted to Farmers New World Life Insurance Company and/or the Proposed Policy Owner, if applicable, as required by state regulations.*

Agent Signature _____

Agent Name (please print or type) _____ Agent/Representative Code Number _____ Date _____

Farmers New World Life Insurance Company

Mercer Island Life Office: 3003 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

A. Primary Proposed Insured				
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. Additional Proposed Insured				
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 _____		
C. Proposed Policy Owner 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 77th 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

Policy Change/Reinstatement Application

Policy Number: _____

A. Primary Insured							
Name of Primary Insured (First/Middle/Last/Suffix i.e. Jr., Sr.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight	
Telephone Number	Driver License Number		License Issue State	Social Security Number (SSN)			
Residence Address (Street, City, State, Zip Code)			Billing Address (if different from Residence Address)				
Primary Language Spoken (if other than English)		Occupation	Duties	Number of Years			
Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment.							
B. Additional Insured							
Name of Additional Insured (First/Middle/Last/Suffix i.e. Jr., Sr.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight	
Relationship to Primary Insured		Driver License Number		License Issue State	Social Security Number (SSN)		
Residence Address (Street, City, State, Zip Code)			Occupation	Duties	Number of Years		
Primary Language Spoken (if other than English)			Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment.				
C. Policy Owner Complete if other than the Primary Insured and when requesting to add or continue Payor Benefits.							
Name of Policy Owner (First/Middle/Last/Suffix i.e. Jr., Sr.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight	
Relationship to Primary Insured		Driver License Number		License Issue State	Social Security Number (SSN)		
Residence Address (Street, City, State, Zip Code)			Occupation	Duties	Number of Years		
Primary Language Spoken (if other than English)			Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment.				
D. Request Information Benefits and Riders may not be available for all plans in all states.							
<input type="checkbox"/> Policy Change <input type="checkbox"/> Reduce/Remove rating or extra charge Add: <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Waiver of Premium (adult policy only) <input type="checkbox"/> Payor/Owner Benefits (juvenile policy only) <input type="checkbox"/> Children's Insurance Rider _____ units			Universal Life plans only: <input type="checkbox"/> Increase Face Amount to \$ _____ <input type="checkbox"/> Increase Planned Premium to \$ _____ Change Death Benefit Option to: (choose one) <input type="checkbox"/> Increasing/Variable (A) <input type="checkbox"/> Level (B) <input type="checkbox"/> Waiver of Deduction or <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month		<input type="checkbox"/> Reinstatement Complete and attach the following, if applicable: ♦ If the policy is a variable plan, attach the appropriate Variable Application Supplement. ♦ If the policy includes a Critical Illness Accelerated Benefit Rider, complete and attach the appropriate Critical Illness Application Supplement.		
E. Children's Insurance Rider Information Complete only for Children's Insurance Rider. List all children to be covered. (Use "Other Remarks" in section J, if necessary.)							
Name of Child (First/Middle/Last/Suffix i.e. Jr., Sr.)		Gender	Relationship	Date of Birth	Social Security Number	Height	Weight
Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, or any other disease or disorder (Indiana and Oregon residents only: during the past 10 years) (Wisconsin residents only: excluding HIV or AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> 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:							

F. Payor/Owner Benefit Information Complete if requesting to add or continue Payor/Owner Benefits. (Use "Other Remarks" in section J, if necessary.)		
Policy Owner's Height:	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? If "Yes," include dates and disorders: <input type="checkbox"/> Yes <input type="checkbox"/> No		
G. Supplementary Information (Please include all details to any "Yes," answers in the appropriate "Additional Details" space in section J.) Questions 1 through 5 should be answered for Insureds age 16 and older, questions 6 and 7 to be answered for all ages.		
	Primary Insured	Additional Insured
1. Have you, in the past five years, used Tobacco or Nicotine products in any form? If "Yes," provide type of Tobacco/Nicotine product and date of last use.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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)? If "Yes," provide date(s), type(s) of violation(s), and location (city and state).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you, in the past 10 years, pled guilty or no contest to, or been convicted of a felony? 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past two years, flown as a student pilot, pilot or crewmember (or do you plan to in the future)? If "Yes," complete an aviation questionnaire.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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)? If "Yes," complete the applicable questionnaire.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the next two years, do you plan to travel or work outside the United States? If "Yes," provide destination, purpose, dates, and length of time.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. 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? If "Yes," provide date(s), type(s) of insurance, final action, and reason(s).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Medical Information (Please include all details to any "Yes," answers in the appropriate "Additional Details" space in section J.) Questions 1; 3 and 4 to be answered for all ages. Questions 2a through 2h should be answered for Proposed Insureds age 16 and older.		
1. Have you ever had, consulted a Physician or other Health Care Provider, or been treated, hospitalized, or taken medication for cerebral palsy or any congenital or birth disorder; cancer, tumor, mass or any malignant growth; asthma or other respiratory disease or disorder; heart murmur or other heart disorder; seizures or other neurological disorder; diabetes; hepatitis; anemia; or any digestive, kidney or urinary disease or disorder? (Indiana and Oregon residents only: during the past 10 years)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. a. Have you ever had, consulted a Physician or other Health Care Provider, or been treated, hospitalized, or taken medication for chest pain of any cause; high blood pressure; high cholesterol; heart attack; stroke or other disease or disorder of the brain or blood vessels; sleep apnea; emphysema; liver disease or disorder; memory loss; Alzheimer's Disease; multiple sclerosis; depression; or attempted suicide? (Indiana and Oregon residents only: during the past 10 years).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you, in the past 10 years, used or been treated for the use of cocaine, marijuana, heroin, or any other addictive or illegal drugs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you, in the past 10 years, been advised by a medical professional to reduce or stop drinking alcohol or received treatment of any kind for the use of alcohol?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you currently drink alcoholic beverages?..... <i>If "Yes," provide the number of drinks, cans or glasses per week: _____</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have you ever tested positive for Human Immunodeficiency Virus (HIV) antibodies or antigens? (Indiana and Oregon residents only: during the past 10 years) (North Dakota residents need not respond.) (Wisconsin residents need disclose only results of an FDA-licensed test given by a member of the medical profession and need not disclose test results received at an anonymous counseling and testing sites or the results of a home test kit.).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Have you ever had, been diagnosed by a medical professional with, or received treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC), or other immune disorder? (Indiana and Oregon residents only: during the past 10 years).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Have you lost more than 15 pounds over the past 12 months?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you, in the past five years, been admitted or advised to be admitted to any hospital or health care facility; or undergone or been advised to have surgery, biopsies, treatment or medical tests, that are not included in your answers to the preceding questions? (Wisconsin residents need only disclose if scheduled or completed.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past 10 years, had any other illness, disease, or injury, not included in your answers to any of the preceding questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Primary Care Physician / Health Care Provider (Use appropriate "Additional Details" space in section J, if necessary.)		
Do you have a Primary Care Physician or Health Care Provider that has not been included in your answers to any of the preceding questions? <i>If "Yes," please provide name, address, telephone number, date last consulted, reason, medication, and treatment prescribed:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

J. Additional Details / Other Remarks When providing details to any "Yes" answers from section H, provide specific 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. *(Use separate sheet signed and dated, if necessary.)*

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

Question Number Details

Additional Insured's Additional Details *(Use for any explanation where space is insufficient. Indicate section and 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

Taxpayer Certification

Under penalties of perjury, I (we), as 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 Farmers New World Life Insurance Company (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 Policy Change/Reinstatement 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 (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, that they are correctly and fully recorded and that no material information or circumstances has been withheld or omitted. I (we) understand that any change and/or reinstatement requested for this policy are not effective until approved by FNWL. I (We) understand and agree that this Application shall become a part of the Policy Contract. I (We) also acknowledge that the change and/or reinstatement policy may be contested by reason of a fraud or misrepresentation of facts material to this change and/or reinstatement for the same period of time following change and/or reinstatement with the same conditions and exceptions as the policy provides with respect to contestability after original issuance. 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

Primary Insured Signature

(or parent if Primary Insured is a juvenile)

State

on

Month, Day, Year

Signed
at

Policy Owner Signature

(if other than Primary Insured), and title, if applicable

State

on

Month, Day, Year

Additional Insured Signature

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

If required, is a sales illustration that conforms to this Policy Change/Reinstatement Application attached? Yes No

Agent Name *(please print or type)*

Agent Signature

Agent/Representative Code Number

Date

Farmers New World Life Insurance Company

Merger Island Life Office: 3003 77th 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 Insured and Additional 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.

SERFF Tracking #:	FNWW-128544224	State Tracking #:	Company Tracking #:	2012 APPLICATION FILING
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			
Project Name/Number:	2012 Life Applications/2012 Life Applications			

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 replaces 31-5153 approved 1/24/2011 e-Life App replaces 31-5167 approved 1/24/2011 PolChg-Rein App replaces 31-4451 approved 12/14/2006 Simple App replaces 31-4472 approved 11/17/2008		

		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):			
App Part 1 - Gen NAIC - Redlined 31-5153 - MIB Rev 7-12.pdf e-Life App - Gen NAIC - Redlined 31-5167 - MIB Rev 7-12.pdf PolChg-Rein App - Gen - Redlined 31-4451 - MIB Rev 7-12.pdf Simple App - Gen - Redlined 31-4472 - MIB Rev 7-12.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	67.69
Simple App	58.16
App Part 1	59.87
PolChg-Rein App	61.63

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

July 6, 2012

FARMERS NEW WORLD LIFE INSURANCE COMPANY
3003 77th 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- 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.

Form E-Life App- 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.

Form PolChg-Rein – Policy Change/Reinstatement Application

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.

Simple App- Simple Application for Life Insurance

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

Authorization section- Form numbers listed may be changed as needed if forms listed are revised or form numbers changed.

MIB Authorization- 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.

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

A. Primary Proposed Insured				
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. Additional Proposed Insured				
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 _____		
C. Proposed Policy Owner 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>)				

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

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

Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, or any other disease or disorder (**Wisconsin residents only**; excluding HIV or AIDS)? Yes No

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

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

List amount of life insurance on:

Mother: _____ Father: _____ Each Child: _____

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

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

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

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

If "Yes," include dates and disorders:

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

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

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

L. 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 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

Important Notice

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

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

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com. }

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

Farmers New World Life Insurance Company

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 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	<i>Whole Life plans only - nonforfeiture options:</i> <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-Up Insurance <i>Premier Whole Life only:</i> Excess Credit Option <input type="checkbox"/> Cash <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Premium/Retirement Deposit Fund <input type="checkbox"/> Reduced Premium Single Premium Rider \$ _____ One-Year Term Rider \$ _____	<i>Universal Life plans only:</i> Death Benefit Option (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 <i>Level Term 2000 (20 and 30 year) only:</i> <input type="checkbox"/> 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? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			

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

Total payment submitted with application: \$ _____

Billing Method:

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

Universal Life Plans: Planned Premium \$ _____ Lump Sum Payment \$ _____

Premium/Retirement Deposit Fund: Initial Payment \$ _____ Regular Payment \$ _____

F. Other Insurance In Force and Replacement Completed for all Proposed Insured(s). (Overflow of details appears in section 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 <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 _____
Primary Proposed Insured Signature (or parent if Primary Proposed Insured is a juvenile)	State	_____	Month, Day, Year
_____	Signed at _____	_____	on _____
Proposed Policy Owner Signature (if other than Primary Proposed Insured), and title, if applicable	State	_____	Month, Day, Year
_____	Proposed Owner's Spouse Signature (where required in community property states when a person other than Policy Owner's spouse is named as Primary Beneficiary)	_____	Policy Co-Owner Signature and title, if applicable

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

_____	_____	_____	_____
Agent Name (please print or type)	Agent/Representative Code Number	Agent Signature	Date

Farmers New World Life Insurance Company

Merger 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

Important Notice

Leave this Disclosure Statement with the Primary Proposed Insured

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

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: {MIB Group Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 (TTY 866-346-3642 for hearing impaired); www.mib.com. }

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

Farmers New World Life Insurance Company

Mercer Island Life Office: 3003 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

Policy Change/Reinstatement Application

Policy Number: _____

A. Primary Insured									
Name of Primary Insured (First/Middle/Last/Suffix i.e. Jr., Sr.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight			
Telephone Number	Driver License Number		License Issue State	Social Security Number (SSN)					
Residence Address (Street, City, State, Zip Code)			Billing Address (if different from Residence Address)						
Primary Language Spoken (if other than English)		Occupation	Duties	Number of Years					
Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment.									
B. Additional Insured									
Name of Additional Insured (First/Middle/Last/Suffix i.e. Jr., Sr.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight			
Relationship to Primary Insured		Driver License Number		License Issue State	Social Security Number (SSN)				
Residence Address (Street, City, State, Zip Code)			Occupation	Duties	Number of Years				
Primary Language Spoken (if other than English)			Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment.						
C. Policy Owner Complete if other than the Primary Insured and when requesting to add or continue Payor Benefits.									
Name of Policy Owner (First/Middle/Last/Suffix i.e. Jr., Sr.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Height	Weight			
Relationship to Primary Insured		Driver License Number		License Issue State	Social Security Number (SSN)				
Residence Address (Street, City, State, Zip Code)			Occupation	Duties	Number of Years				
Primary Language Spoken (if other than English)			Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete an Interpretation Amendment.						
D. Request Information Benefits and Riders may not be available for all plans in all states.									
<input type="checkbox"/> Policy Change <input type="checkbox"/> Reduce/Remove rating or extra charge Add: <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Waiver of Premium (adult policy only) <input type="checkbox"/> Payor/Owner Benefits (juvenile policy only) <input type="checkbox"/> Children's Insurance Rider _____ units			<i>Universal Life plans only:</i> <input type="checkbox"/> Increase Face Amount to \$ _____ <input type="checkbox"/> Increase Planned Premium to \$ _____ Change Death Benefit Option to: (choose one) <input type="checkbox"/> Increasing/Variable (A) <input type="checkbox"/> Level (B) <input type="checkbox"/> Waiver of Deduction or <input type="checkbox"/> Monthly Disability Benefit \$ _____ per month			<input type="checkbox"/> Reinstatement Complete and attach the following, if applicable: ♦ If the policy is a variable plan, attach the appropriate Variable Application Supplement. ♦ If the policy includes a Critical Illness Accelerated Benefit Rider, complete and attach the appropriate Critical Illness Application Supplement.			
E. Children's Insurance Rider Information Complete only for Children's Insurance Rider. List all children to be covered. (Use "Other Remarks" in section J, if necessary.)									
Name of Child (First/Middle/Last/Suffix i.e. Jr., Sr.)		Gender	Relationship	Date of Birth	Social Security Number	Height	Weight		
Has any child ever had, been treated, or hospitalized for any congenital or birth disorder, any heart disorder, cancer, tumor, diabetes, seizures, or any other disease or disorder (Indiana and Oregon residents only: during the past 10 years) (Wisconsin residents only: excluding HIV or AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> 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:									

F. Payor/Owner Benefit Information Complete if requesting to add or continue Payor/Owner Benefits. (Use "Other Remarks" in section J, if necessary.)			
Policy Owner's Height:	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? If "Yes," include dates and disorders: <input type="checkbox"/> Yes <input type="checkbox"/> No			
G. Supplementary Information (Please include all details to any "Yes," answers in the appropriate "Additional Details" space in section J.) Questions 1 through 5 should be answered for Insureds age 16 and older, questions 6 and 7 to be answered for all ages.		Primary Insured	Additional Insured
1. Have you, in the past five years, used Tobacco or Nicotine products in any form? If "Yes," provide type of Tobacco/Nicotine product and date of last use.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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)? If "Yes," provide date(s), type(s) of violation(s), and location (city and state).		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you, in the past 10 years, pled guilty or no contest to, or been convicted of a felony? 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.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past two years, flown as a student pilot, pilot or crewmember (or do you plan to in the future)? If "Yes," complete an aviation questionnaire.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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)? If "Yes," complete the applicable questionnaire.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the next two years, do you plan to travel or work outside the United States? If "Yes," provide destination, purpose, dates, and length of time.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. 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? If "Yes," provide date(s), type(s) of insurance, final action, and reason(s).		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Medical Information (Please include all details to any "Yes," answers in the appropriate "Additional Details" space in section J.) Questions 1; 3 and 4 to be answered for all ages. Questions 2a through 2h should be answered for Proposed Insureds age 16 and older.			
1. Have you ever had, consulted a Physician or other Health Care Provider, or been treated, hospitalized, or taken medication for cerebral palsy or any congenital or birth disorder; cancer, tumor, mass or any malignant growth; asthma or other respiratory disease or disorder; heart murmur or other heart disorder; seizures or other neurological disorder; diabetes; hepatitis; anemia; or any digestive, kidney or urinary disease or disorder? (Indiana and Oregon residents only: during the past 10 years)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. a. Have you ever had, consulted a Physician or other Health Care Provider, or been treated, hospitalized, or taken medication for chest pain of any cause; high blood pressure; high cholesterol; heart attack; stroke or other disease or disorder of the brain or blood vessels; sleep apnea; emphysema; liver disease or disorder; memory loss; Alzheimer's Disease; multiple sclerosis; depression; or attempted suicide? (Indiana and Oregon residents only: during the past 10 years).....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you, in the past 10 years, used or been treated for the use of cocaine, marijuana, heroin, or any other addictive or illegal drugs?.....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you, in the past 10 years, been advised by a medical professional to reduce or stop drinking alcohol or received treatment of any kind for the use of alcohol?.....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you currently drink alcoholic beverages?..... <i>If "Yes," provide the number of drinks, cans or glasses per week: _____</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities?.....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have you ever tested positive for Human Immunodeficiency Virus (HIV) antibodies or antigens? (Indiana and Oregon residents only: during the past 10 years) (North Dakota residents need not respond.) (Wisconsin residents need disclose only results of an FDA-licensed test given by a member of the medical profession and need not disclose test results received at an anonymous counseling and testing sites or the results of a home test kit.).....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Have you ever had, been diagnosed by a medical professional with, or received treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC), or other immune disorder? (Indiana and Oregon residents only: during the past 10 years).....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Have you lost more than 15 pounds over the past 12 months?.....		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you, in the past five years, been admitted or advised to be admitted to any hospital or health care facility; or undergone or been advised to have surgery, biopsies, treatment or medical tests, that are not included in your answers to the preceding questions? (Wisconsin residents need only disclose if scheduled or completed.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, in the past 10 years, had any other illness, disease, or injury, not included in your answers to any of the preceding questions?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Primary Care Physician / Health Care Provider (Use appropriate "Additional Details" space in section J, if necessary.)			
Do you have a Primary Care Physician or Health Care Provider that has not been included in your answers to any of the preceding questions? <i>If "Yes," please provide name, address, telephone number, date last consulted, reason, medication, and treatment prescribed:</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

J. Additional Details / Other Remarks When providing details to any "Yes" answers from section H, provide specific 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. *(Use separate sheet signed and dated, if necessary.)*

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

Additional Insured's Additional Details *(Use for any explanation where space is insufficient. Indicate section and 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

Taxpayer Certification

Under penalties of perjury, I (we), as 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 Farmers New World Life Insurance Company (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 Policy Change/Reinstatement 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 (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, that they are correctly and fully recorded and that no material information or circumstances has been withheld or omitted. I (we) understand that any change and/or reinstatement requested for this policy are not effective until approved by FNWL. I (We) understand and agree that this Application shall become a part of the Policy Contract. I (We) also acknowledge that the change and/or reinstatement policy may be contested by reason of a fraud or misrepresentation of facts material to this change and/or reinstatement for the same period of time following change and/or reinstatement with the same conditions and exceptions as the policy provides with respect to contestability after original issuance. 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 Insured Signature

State

Month, Day, Year

(or parent if Primary Insured is a juvenile)

Signed
at

on

Policy Owner Signature

State

Month, Day, Year

(if other than Primary Insured), and title, if applicable

Additional Insured Signature

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

If required, is a sales illustration that conforms to this Policy Change/Reinstatement Application attached? Yes No

Agent Name (please print or type)

Agent Signature

Agent/Representative Code Number

Date

Farmers New World Life Insurance Company

Merger 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

Important Notice

Leave this Disclosure Statement with the Primary Insured and Additional 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



FARMERS
LIFE INSURANCE

Simple Application for Life Insurance

A. Proposed Insured Information

Name of Proposed Insured: _____ Date of Birth: _____
Social Security Number (SSN): _____ Gender: _____ Height: _____ Weight: _____
Residence Address: _____ Place of Birth: _____
Telephone Numbers: Primary: _____ Secondary: _____ Occupation: _____
Are you a U.S. Citizen or do you have a Green Card? _____ Green Card Alien Registration Number: _____
Is the Proposed Insured the Policy Owner? _____

B. Driver License Information

Issue State: _____ License Number: _____
1. Have you, in the past five years, pled guilty to or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless/careless driving; or in the past three years, had three or more moving violations, or had your driver's license suspended, revoked, cancelled or withdrawn?

C. Proposed Policy Owner Information

Name of Proposed Policy Owner: _____ Date of Birth: _____
Relationship to Proposed Insured: _____ Tax Payer ID Number or SSN: _____ Gender: _____

D. Product Information: Plan, Class, Face Amount and Benefits

Plan: _____ Class: _____ Face Amount: _____ Single Premium: _____
Benefits: _____

E. Sales Illustration

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

F. Billing and Payment Information: Refer to Bank Authorization form

Billing Method: _____ Payment submitted with application: _____
Billing Address: _____

G. Temporary Insurance Eligibility Question

In the past two years, has the Proposed Insured received any treatment or medication for, or been diagnosed as having any kind of cancer or tumor, stroke, drug or alcohol dependency, or any disease or disorder of the heart, liver or kidney?

H. Beneficiary Information

Primary/Contingent	Beneficiary Name(s),	Share %,	Date of Birth	Relationship to Proposed Insured
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Include delay clause? _____ Number of days: _____

I. Other Insurance and/or Pending Application(s) for Life Insurance

Is there any life insurance or annuity in force or application pending on the life of the Proposed Insured?

Will any in-force life insurance or annuity be reduced, replaced, or discontinued; or will payment of premiums be stopped if the insurance requested is issued?

Details:

Company	Insured	Policy Number	Life Amount	ADB Amount	Pending?	In-Force?	Replacing?
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Is the insurance applied for intended to be a 1035 Exchange?

J. Owner Benefit Information

Proposed Policy Owner's Height:

Proposed Policy Owner's Weight:

1. Have you, the Proposed Policy Owner, in the past five years, received any treatment or medication for, or been diagnosed as having, appendicitis, any kind of cancer or tumor, diabetes, drug or alcohol dependency, gastric reflux, hernia, pneumonia, pregnancy, stroke, or disability, including receiving disability income benefits; or have you ever had any disease or disorder of the heart, immune system, kidney, liver, or lungs?

K. Children's Insurance Rider Information

Child Name	Gender	Relationship to Proposed Insured	Date of Birth	SSN	Height	Weight	Eligibility
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1. Has any child ever had, or been treated or hospitalized for, appendicitis, asthma, cancer, congenital or birth disorder, diabetes, heart disorder, hernia, leukemia, premature birth, RSV(Respiratory Syncytial Virus), scoliosis, seizures, tonsillectomy, tubes in ears, tumor, or any other disease or disorder?

L. Juvenile Plan Information

1. Amount of life insurance on:
Mother: Father: Household Income:
2. Do both parents have at least as much insurance in force or applied for as the Proposed Insured?
3. Amount of life insurance on each child:
4. Do all children in household have at least as much insurance in force or applied for as the Proposed Insured?

M. Medical and Supplemental Information Regarding the Proposed Insured

1. Have you, in the past three years, participated in or do you plan to participate in any of the following activities: aeronautics, including ballooning, hang gliding, parachuting, or skydiving; racing, including boat, car, or motorcycle; scuba diving; hiking, including mountain climbing or rock climbing; or any similar hazardous activities?
2. Do you anticipate residence or travel, including military deployment, outside the United States during the next two years (excluding travel as a pilot or crew member of a commercial flight)?
3. Do you anticipate the total number of days of travel or residence, including military deployment, outside the United States during the next two years to exceed 90 days (excluding travel as a pilot or crew member of a commercial flight)?
4. Have you, in the past three years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline flight?
5. Have you, in the past seven years, had, consulted a physician or other healthcare provider(s) for, or been treated or hospitalized for or taken medication for any of the following: any diseases or disorders of the heart (including rheumatic fever), circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs (including allergies or sleep apnea); any mental or nervous disorders (including depression, anxiety, or suicide); muscular, spinal, joint, or bone disorders or injuries (including concussions); high blood pressure; elevated cholesterol; cancer/skin cancer; stroke; epilepsy/seizures (including dizziness or fainting); arthritis; congenital defects or physical impairments?

6. Have you ever been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder, or have you tested positive for HIV antibodies or antigens?
7. Have you, in the past 12 months, been hospitalized for 24 or more consecutive hours?
8. Have you scheduled or been advised to have, a surgical operation, diagnostic test, or evaluation that has not been completed?
9. Have you, in the past 12 months, used Tobacco or Nicotine products in any form?
10. Have you, in the past 10 years, used illegal drugs, or consulted a healthcare provider or treatment facility for abuse of alcohol or drugs (including prescription drugs)?
11. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, been incarcerated for a felony offense, or been placed on probation or parole for a felony offense, or are felony charges currently outstanding against you?
12. Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities?
13. Have you, within the past 12 months, been confined to, or been advised to use the services of any of the following: adult day care facility, assisted living facility, home health care services, nursing home, or residential care facility?
14. Do you require the assistance or supervision of another person or device of any kind for any of the following: getting in or out of a bed or chair; self-care, such as eating, dressing, bathing and/or using the bathroom; or walking, such as need for a walker, wheelchair or scooter?
15. Do you require the assistance or supervision of another person to perform any of the following: doing laundry, making financial or banking decisions, housekeeping, making telephone calls, preparing meals, shopping, or taking medication?
16. Have you seen a physician within the past two years?
17. Have you, in the past six months, experienced an unintentional or unexplained weight loss, not due to increase in exercise or intentional change in diet?
18. Do you participate in activities outside the home?
19. Have you had two or more falls in the past 12 months?

Additional Information

Certification, Authorization and Acknowledgement Signatures

Temporary Insurance Agreement (TIA) Coverage

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

Illustration

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

Taxpayer Certification

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

- 1. The Social Security Number shown on this form is my correct taxpayer identification number (TIN) (or I am waiting for a number to be issued to me), **and**
- 2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(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, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
- 3. I am a U.S. person (including a U.S. resident alien).

{Certification 2 above does not apply to me (us).}

Authorization to Obtain and Disclose Information

I (We) understand that non-medical and medical information ("Personal Information") will be used by Farmers New World Life Insurance Company (FNWL) to determine my and/or the minor child's eligibility for the insurance coverage applied for in this Application as well as to determine eligibility and evaluate claims for benefits under any policy issued in connection with this Application. Personal Information includes, but is not limited to information about me and/or the minor child regarding: mental and physical health, including information about medical care, treatment, advice, alcohol and nicotine use, drug use, prescription drug history, as well as communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; motor vehicle, financial, and criminal records; hazardous activities; and avocations.

By signing this Application, I (we) authorize licensed physicians; medical practitioners; hospitals; clinics or other medical or medically-related facilities; insurance companies; the Medical Information Bureau (MIB); the Veterans Administration; the Social Security Administration; and consumer reporting agencies to release Personal Information to FNWL, its reinsurers, and their legal representatives. **{Furthermore, I (we) authorize FNWL, or its reinsurers, to make a brief report of my (our) personal health information to MIB.}** A copy of this authorization shall be as valid as the original. This authorization is valid for 24 months from the date of this Application. I (We), as well as any person authorized to act on my (our) behalf, may, upon written request, obtain a copy of this authorization. I (We), as well as any person authorized to act on my (our) behalf, may revoke this authorization at any time by sending written notice to FNWL. Changing, revoking or failing to sign this authorization will impair processing of the Application; as a result, the Application may be denied.

I (We) understand that some or all of the data collected to create this Application, including any electronic or voice signature, may be transmitted and/or maintained by FNWL in electronic format. I (we) understand that my (our) electronic or voice signature(s) printed/indicated on this Application as shown below is my (our) consent to complete this Application by electronic means. A paper copy of this Application with my (our) electronic or voice signature(s) printed/indicated on the paper Application will be provided to me (us) with the Policy Contract, if issued, or upon receipt by FNWL of my (our) written request. My (our) electronic or voice signature(s) will not be attached to or used for any other transaction unless I (we) provide my (our) consent, which would be indicated with new electronic or voice signature(s) for the separate transaction.

Acknowledgement

I (We) have read, or have had read to me (us), the Important Notice disclosure statement listed on Form 31-5287 given to me (us) on this date. I (We) acknowledge that this Application signed by me (us), will become a part of the policy if issued by FNWL. I (We) also acknowledge that I (we) have read, or have had read to me (us), and that I (we) understand the fraud warning and/or other notice listed on Form 31-4226 for my (our) state of residence, if any. I (We) have read and reviewed the above statements and the answers to the questions on this Application and hereby represent that such statements and answers are true and complete to the best of my (our) knowledge and belief. **Except as stated in the Temporary Insurance Agreement (if any) provided upon payment of premium, I (We) understand and acknowledge that no policy will be issued and no insurance coverage is in force unless: (a) this Application, along with any additional applications, addendums, amendments, questionnaires, and medical examination forms have been completed and signed by me (us) and received by the Company, (b) the full first modal premium has been paid, and (c) the Application has been approved by FNWL without modification. In the event FNWL approves the Application other than as applied for ("with modification"), no policy will be issued and no coverage will be in force until I (we) have also accepted in writing the policy as modified. I (We) understand and agree that no agent is authorized to: (a) make or modify contracts, (b) waive any of FNWL's rights or requirements, or (c) accept risks or make any determination as to insurability.**

Signature of Proposed Insured	Signed in	State	on	Date/Time stamp
Signature of Proposed Policy Owner (if other than the Proposed Insured)	Signed in	State	on	Date/Time stamp
Signature of Policy Owner's Spouse <small>(where required in community property states)</small>	Signed in	State	on	Date/Time stamp

I certify that I have truly and accurately recorded on this Application the information given by the Proposed Insured and Policy Owner(s)/Spouse, verified their identity(ies) and witnessed their signature(s). To the best of your knowledge, is there any life insurance or annuity in-force, or application pending on the life of the Proposed Insured? Yes No. To the best of your knowledge, will the life insurance applied for replace or reduce current coverage with this or any other company? Yes No. If a replacement, was sales material used in the solicitation? Yes No. *Copies of the materials must be submitted to Farmers New World Life Insurance Company and/or the Proposed Policy Owner, if applicable, as required by state regulations.*

Agent Signature

Agent Name (please print or type)

Agent/Representative Code Number

Date