

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 2 - Medical History Statement

Name of Proposed Insured (Please print: First/Middle/Last/Suffix i.e. Jr., Sr.)	Date of Birth (mm/dd/yyyy)	Social Security Number (SSN)
---------------------------------------------------------------------------------	----------------------------	------------------------------

A. Medical Information (Please include all details to any "Yes" answers, or any additional information from this section, in the Additional Details section on the following page.)

1. Have you lost more than 15 pounds over the past 12 months? ☐ Yes ☐ No
2. Do you have any congenital or birth disorders? ☐ Yes ☐ No
3. Have you ever consulted a Physician or other Health Care Provider, been treated, hospitalized, or taken medication for (*Indiana and Oregon residents only*: during the past 10 years):
 - a. High blood pressure, high cholesterol, heart attack, murmur, stroke, chest pain, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☐ No
 - b. Cancer, tumor, mass, or any malignant or benign growth? ☐ Yes ☐ No
 - c. Diabetes, anemia or other blood disorder (excluding HIV), or disease or disorder of the thyroid or any other glands? ... ☐ Yes ☐ No
 - d. Hepatitis, cirrhosis, or other disease or disorder of the liver, pancreas or spleen? ☐ Yes ☐ No
 - e. Depression, or other psychiatric or mental health disease or disorder? ☐ Yes ☐ No
 - f. Seizures, multiple sclerosis, memory loss, or other disease or disorder of the nervous system? ☐ Yes ☐ No
 - g. Sleep apnea, asthma, emphysema, or other disease or disorder of the lungs or respiratory system? ☐ Yes ☐ No
 - h. Kidney disorder, or other disease or disorder of the urinary system? ☐ Yes ☐ No
 - i. Colitis, or any other disease or disorder of the digestive system? ☐ Yes ☐ No
4. Have you ever tested positive for Human Immunodeficiency Virus (HIV) antibodies or antigens? (*Indiana and Oregon residents only*: during the past 10 years) (*California residents* need only reveal results of HIV tests taken for the purpose of obtaining insurance.) (*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.) ☐ Yes ☐ No
5. Have you ever had, been diagnosed by a medical professional with, or received treatment for Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), or other immune disorder? (*Indiana and Oregon residents only*: during the past 10 years) (*California residents only*: answer for immune disorder excluding HIV status.) ☐ Yes ☐ No
6. Have you ever used, or been treated for the use of cocaine, marijuana, heroin, or any other addictive or illegal drugs? ☐ Yes ☐ No
7. Have you ever been advised by a medical professional to reduce or stop drinking alcohol, or received treatment of any kind for the use of alcohol? ☐ Yes ☐ No
8. Do you currently drink alcoholic beverages? ☐ Yes ☐ No
If "Yes," type and number of drinks, cans or glasses per week _____
9. Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities? ☐ Yes ☐ No
10. 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 any of the preceding questions? (*Wisconsin residents* need only disclose if scheduled or completed.) ☐ Yes ☐ No
11. Have you had any other illness, disease, or injury, not included in your answers to any of the preceding questions? ☐ Yes ☐ No
12. Have you ever attempted suicide or made a suicidal gesture? ☐ Yes ☐ No

B. Family History (Use "Additional Details" in section C, if necessary.)

	If Living	If Living or While Living			If Deceased	
	Current Age	Health Status	List all Diseases or Disorders	Age at Diagnosis	Cause of Death	Age at Death
Father						
Mother						
Siblings# _____						

C. Additional Details When providing details to any "Yes" answers, 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 a separate sheet signed and dated by the Proposed Insured, if necessary.)*

Section/Question Number Details

D. Primary Care Physician / Health Care Provider

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? ☐ Yes ☐ No

If "Yes," please provide name, address, and telephone number:

Date last consulted, reason, medication, and treatment prescribed:

Authorization and Acknowledgement Signatures

I understand that portions or all of the data collected to create this Medical History Statement/Application for Life Insurance Part 2 (Medical History Statement), including my signature, may be transmitted by electronic means and/or retained in electronic format. By signing below, I consent to this transaction by electronic means and confirm that I have not withdrawn my consent. I will receive a paper copy of this Medical History Statement with the Policy Contract, if issued, or upon receipt of a written request directed to Farmers New World Life Insurance Company.

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

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

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

Signed at _____ on _____
State Month, Day, Year

Paramedical Examiner Signature

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

Agent or Witness Signature *(if present)*

Agent Code or Relationship

Paramedical Examiner use only: *Urine Specimen must be obtained with every exam. Send Blood and Urine Specimens to assigned laboratory in accordance with instructions provided to your company.*

Examination was completed at:

☐ Proposed Insured's office ☐ Proposed Insured's home ☐ My office ☐ Other _____

Name of Examiner *(please print or type)*

Name of Firm

Was the exam conducted in a language other than English? ☐ Yes ☐ No *If "Yes," please complete an Interpretation Amendment and the following:*

a. Was an interpreter used? ☐ Yes ☐ No *If "Yes," what is the interpreter's relationship to the Proposed Insured?* _____

b. What language was used? _____

Farmers New World Life Insurance Company

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



FARMERS
LIFE INSURANCE

Physician's Report

Proposed Insured					
Name					
Height		Weight	Males Only		
			Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen (At Umbilicus Relaxed)
Ft.	In.	Lbs.	In.	In.	In.
Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Blood Pressure (If initial BP exceeds 130/80, record two additional readings 2 minutes apart.)					
		At Rest	Additional Reading		Additional Reading
Systolic					
Diastolic					
Heart Exam					
Rate:		Is heart rhythm irregular? <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregularities per minute:		
If irregular, describe:					
Is there a murmur present? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic	Grade:		
Describe location and note point of maximal intensity (PMI) on chart with X:					
Characteristics of the murmur:					
Does the murmur radiate to <input type="checkbox"/> carotid arteries <input type="checkbox"/> axilla Murmur after exercise: <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Unchanged <input type="checkbox"/> Absent What is your impression of the murmur?					
History					
Is there any history of cancer, diabetes, psychiatric, hematologic, or cardiovascular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes," provide details:					

Review of System and Exam						
	Indicate History or Symptoms			Exam Findings		
	Y	N	Details	Normal	Abnormal	Details
HEENT						
Skin						
Lymph nodes						
Endocrine/Thyroid						
Respiratory						
Gastrointestinal						
Neuro/Musculoskeletal						
Mental status						
Cranial nerves						
Reflexes						
Gait						
Weakness						
Paralysis						
Edema						
Other						

Instructions: Blood and Urine Specimen must be obtained with every exam. Enclose this form in the Blood and Urine Specimen kit and mail in accordance with the instructions provided in the kit.

Physician's Signature _____ Signed at _____ on _____
City, State Month, Day, Year

Physician Name and Exam Company _____ Address and Telephone Number _____



Fraud Warnings and Other Notices

Please review the warning and/or notice applicable to your state, if any.

Alabama, Arkansas, Louisiana, Rhode Island and West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia – **“WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.”**

Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Georgia – NOTICE: The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Illinois – (Public Act 96-1513, the “Civil Union Law”) Farmers New World Life Insurance Company recognizes civil unions entered into in accordance with Illinois law. Parties to a civil union are treated identically to spouses of a marriage.

Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland – “Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

Minnesota Guarantee Association Notice – *This applies only to the variable funds of life and annuity policies: This policy or contract is not protected by the Minnesota Life and Health Insurance Guaranty Association or the Minnesota Insurance Guaranty Association. In the case of insolvency, payment of claims is not guaranteed. Only the assets of this insurer will be available to pay your claim.*

New Jersey – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

Tennessee, Virginia and Washington – “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

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: PO Box 182325, Columbus, OH 43218-2325 (614) 764-9975

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