Farmers New World Life Insurance Company
Life Home Office: 3120 139th Ave SE Suite 300, Bellevue, WA 98005 / 1-800-238-9671
Mailing address: PO Box 248831, Oklahoma City, OK 73124
Variable Policy Service Office: PO Box 724208, Atlanta, GA 31139 / 1-877-376-8008
Index UL Service Center: PO Box 725409, Atlanta, GA 31139 / 1-888-794-0608

FARMERS 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.

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

_____ _____
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
Overflow Addendum

Proposed Insured Name:

Policy Number:

Additional Details Continued:

I (We) understand that the information recorded in this Addendum was provided by me (us) in response to the questions in the application. I (We) have reviewed the information recorded and believe that it is true and correct to the best of my (our) knowledge. I (We) understand that the information provided by me (us) in the application process and as recorded on this Addendum will be relied upon by Farmers New World Life Insurance Company to determine the insurability of the Proposed Insured. I (We) acknowledge that this Addendum, completed and signed by me (us), will be attached to and made part of the Policy Contract, if issued.

Signed at _____ on _____

Proposed Insured Signature (or parent if Proposed Insured is a juvenile) — State — Month, Day, Year

Proposed Policy Owner Signature (if other than Proposed Insured) — State — Month, Day, Year

Agent or Witness Signature (if present)