

# Farmers New World Life Insurance Company

Mercer Island Life Office: 3003 77<sup>th</sup> Ave. S.E., Mercer Island, WA 98040-2890 (206) 232-8400

Columbus Life Office: P.O. Box 182325, Columbus, OH 43218-2325 (614) 764-9975

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



**FARMERS**  
LIFE INSURANCE

Application 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)
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**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? \_\_\_\_\_

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## Physician's Report

<b>Proposed Insured</b>					
Name _____					
<b>Height</b>		<b>Weight</b>		Males Only	
				Chest (Full Inspiration)	Chest (Forced Expiration)
Ft.	In.	Lbs.	In.	In.	Abdomen (At Umbilicus Relaxed)
					In.
Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No    Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Blood Pressure</b> (If initial BP exceeds 130/80, record two additional readings 2 minutes apart.)					
		At Rest	Additional Reading		Additional Reading
Systolic					
Diastolic					
<b>Heart Exam</b>					
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?					
<b>History</b>					
Is there any history of cancer, diabetes, psychiatric, hematologic, or cardiovascular disorder? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
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						
Breasts						
Respiratory						
Gastrointestinal						
Genitourinary						
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 \_\_\_\_\_