

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)
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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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FARMERS
LIFE INSURANCE

Physician's Report

Proposed Insured					
Name _____					
Height		Weight		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					
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:					