Farmers® Privacy Notice

In the course of our business relationship with you, we collect information about you that is necessary to provide you with our products and services. We treat this information as confidential and recognize the importance of protecting it. We value your confidence in us.

You trust us with an important part of your financial life. We are proud of our privacy policies and procedures and encourage you to review them carefully.

This notice from the member companies of the Farmers Insurance Group of Companies® listed on the back of this notice* describes our privacy practices regarding information about our customers and former customers that obtain financial products or services from us for personal, family or household purposes. ***When state law is more protective of individuals than federal privacy law, we will protect information in accordance with state law consistent with the requirements of federal preemption.***

Information we collect

We collect and maintain information about you to provide you with the coverage, product or service you request and to service your account.

We collect certain information ("nonpublic personal information") about you and the members of your household ("you") from the following sources:

- Information we receive from you on applications or other forms, such as your social security number, assets, income and property information;
- Information about your transactions with us, our affiliates or others, such as your policy coverage, premiums and payment history;
- Information we receive from a consumer reporting agency or insurance support organization, such as motor vehicle records, credit report information and claims history; and
- If you obtain a life, long-term care or disability product, information we receive from you, medical professionals who have provided care to you and insurance support organizations regarding your health.

How we protect your information

At Farmers, our customers are our most valued assets. Protecting your privacy is important to us. We restrict access to personal information about you to those individuals, such as our employees and agents, who provide you with our products and services. We require those individuals to whom we permit access to your customer information to protect it and keep it confidential. We maintain physical, electronic, and procedural safeguards that comply with applicable regulatory standards to guard your nonpublic personal information.

We do not disclose any nonpublic personal information about you, as our customer or former customer, except as described in this notice.

Information we disclose

We may disclose the nonpublic personal information we collect about you, as described above, to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements and to other third parties, all as permitted by law.

Many employers, benefit plans or plan sponsors restrict the information that can be shared about their employees or members by companies that provide them with products or services. If you have a relationship with Farmers or one of its affiliates as a result of products or services provided through an employer, benefit plan or plan sponsor, we will abide by the privacy restrictions imposed by that organization.

We are permitted to disclose personal health information (1) to process your transaction with us, for instance, to determine eligibility for coverage, to process claims or to prevent fraud; (2) with your written authorization, and (3) otherwise as permitted by law.

Sharing information with affiliates

The Farmers family encompasses various affiliates that offer a variety of financial products and services in addition to insurance. Sharing information enables our affiliates to offer you a more complete range of products and services.

(Continued on next page)

We may disclose nonpublic personal information, as described under **Information we collect,** to our affiliates, which include:

- Financial service providers such as insurance companies and reciprocals, investment companies, underwriters and brokers/dealers; and
- Non-financial service providers, such as management companies, attorneys-in-fact and billing companies.

We are permitted by law to share with our affiliates information about our transactions and experiences with you.

In addition, we may share with our affiliates consumer report information, such as information from credit reports and certain application information, that we have received from you and from third parties, such as consumer reporting agencies and insurance support organizations.

Your choice

If it is your decision not to opt-out and to allow sharing of your information with our affiliates, you do not need to request an Opt-Out Form or respond to us in any way.

If you have previously submitted a request to opt-out on each of your policies, no further action is required.

If you prefer that we not share consumer report information with our affiliates, except as otherwise permitted by law, you may request an Opt-Out Form by calling toll free, 1-800-327-6377, (please have all of your policy numbers available when requesting Opt-Out Forms). A form will be mailed to your attention. Please verify that all of your Farmers policy numbers are listed. If not, please add the policy numbers on the form and mail to the return address printed on the form. We will implement your request within a reasonable time after we receive the form.

Modifications to our Privacy Policy

We reserve the right to change our privacy practices in the future, which may include sharing nonpublic personal information about you with nonaffiliated third parties. Before we do that, we will provide you with a revised privacy notice and give you the opportunity to opt-out of that type of information sharing.

Website

Our website privacy notices, such as the one located at farmers.com, contain additional information particular to website use. Please pay careful attention to those notices if you transmit personal information to Farmers over the Internet.

Recipients of this notice

We are providing this notice to the named policyholder residing at the mailing address to which we send your policy information. If there is more than one policyholder on a policy, only the named policyholder on that policy will receive this notice, though any policyholder may request a copy of this notice. You may receive more than one copy of this notice if you have more than one policy with Farmers. You also may receive notices from affiliates, other than those listed below. Please read those notices carefully to determine your rights with respect to those affiliates' privacy practices.

More information about the federal laws

This notice is required by federal law. If you would like additional information about these federal laws, please visit our website at farmers.com.

Signed:

Farmers Insurance Exchange, Fire Insurance Exchange, Truck Insurance Exchange, Mid-Century Insurance Company, Farmers Insurance Company, Inc. (A Kansas Corp.); Farmers Insurance Company of Arizona, Farmers Insurance Company of Idaho, Farmers Insurance Company of Oregon, Farmers Insurance Company of Washington, Farmers Insurance of Columbus, Inc.; Farmers New Century Insurance Company, Farmers Group, Inc.; Farmers Reinsurance Company, Farmers Services Insurance Agency, Farmers Services Corporation, Farmers Texas County Mutual Insurance Company, Farmers Underwriters Association, Farmers Value Added, Inc.; Farmers Financial Solutions, LLC member FINRA & SIPC**; FFS Holding, LLC; Farmers Services, LLC; ZFUS Services, LLC; Leschi Life Assurance Company, FIG Holding Company, FIG Leasing Co., Inc.; Fire Underwriters Association, Illinois Farmers Insurance Company, Mid-Century Insurance Company of Texas, Prematic Service Corporation (California), Prematic Service Corporation (Nevada), Texas Farmers Insurance Company, Farmers New World Life Insurance Company, Truck Underwriters Association, Civic Property and Casualty Company, Exact Property and Casualty Company and Neighborhood Spirit Property and Casualty Company.

*The above is a list of the affiliates on whose behalf this privacy notice is being provided. It is not a comprehensive list of all affiliates of the Farmers Insurance Group of Companies.

**You may obtain more information about the Securities Investor Protection Corporation (SIPC) including the SIPC brochure by contacting SIPC at (202) 371-8300 or via the internet at www.sipc.org. For information about FINRA and Broker Check you may call the FINRA Broker Check hotline at (800) 289-9999 or access the FINRA website at www.finra.org.

General Life Application

California

Farmers New World Life Insurance Company

FARMERS® LIFE INSURANCE

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 1-877-376-8008

FARMERS INSURANCE GROUP Symbol of Superior Service

FARMERS LIFE INSURANCE

Application for Life Insurance – Agent Instructions:

What Forms Do I Need?

Submit an Application for Life Insurance to initiate the underwriting process.
Include the following forms, depending on your client's needs and your state's requirements:

- **Client's check,** made payable to Farmers New World Life
- **Replacement Notice,** if replacement is involved.
- **1035 Exchange forms,** if replacement is 1035 Exchange
- **Notice and Consent/Authorization form(s)**
- **ABR-TI Disclosure form,** if applicable
- **Critical Illness Disclosure and Critical Illness Application Supplement**, if applicable
- **Signed Sales Illustration,** if applicable
- **Privacy Notice (25-7660),** leave with Proposed Policy Owner

The following forms are only applicable to the Farmers EssentialLife® Variable Universal Life Plan:

- **Application Supplement (31-4423)**
- **Disclosure for VUL (31-4229)**
- **FFS, LLC New Account form (31-6034)**

In some situations, there may be additional form requirements such as, but not limited to the W-8 or an Interpretation Amendment. Forms can be found in the Packet or on LifeNet.

Temporary Insurance Agreement Reminder:

TIA coverage is limited to $500,000. The Proposed Insured is not eligible for TIA coverage if:

- the Proposed Insured is less than15 days of age, or 70 years of age or older on the date this Application for Life Insurance is signed, or
- the medical TIA questions has been answered "Yes" or left blank

If the Proposed Insured does not qualify for TIA coverage, no premium should be collected until the policy is issued and delivered to the Proposed Policy Owner.

Obtain OFT if Qualified:

OFT is encouraged, although not required. Be sure to indicate on the Agent's Report when OFT has been obtained.

Paramedical Examination:

A paramedical examiner will complete the Medical History Statements/Application for Life Insurance Part 2 if this application requires a Paramedical Examination or is for Preferred Class or Premier Class.

Where Do I Send My Forms?

Mail all applications and signed documents, except Variable applications, to:

Farmers New World Life Insurance Co.
P.O. Box 248831
Oklahoma City, OK 73124-8831

Mail all Variable applications and signed documents to:

Farmers New World Life Insurance Co.
3003 77th Ave SE
Mercer Island WA, 98040

(for agent's use only)

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 INSURANCE GROUP Symbol of Superior Service

FARMERS LIFE INSURANCE

Application Number: LA

Application for Life Insurance Part 1

A. Primary Proposed Insured

Name of Primary Proposed Insured *(First/Middle/Last/Suffix i.e. Jr., Sr.)*

Gender ☐ Male ☐ Female	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State, Country)*	Social Security Number (SSN)

Marital Status	Driver License Number	License Issue State	Height	Weight

Residence Address *(Street, City, State, Zip Code)*

Billing Address *(Street, City, State, Zip Code) (if different from Residence Address)*

Primary Telephone Number	Secondary Telephone Number	Primary Language Spoken *(if other than English)*

Occupation	Duties	Number of Years

Employer Name	Annual Income	Annual Household Income

Parent Name *(if Primary Proposed Insured is a juvenile and if other than Proposed Policy Owner)*

B. Additional Proposed Insured

Name of Additional Proposed Insured *(First/Middle/Last/Suffix i.e. Jr., Sr.)*

Gender ☐ Male ☐ Female	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State, Country)*	Social Security Number (SSN)

Marital Status	Driver License Number	License Issue State	Height	Weight

Residence Address *(Street, City, State, Zip Code)*

Occupation	Duties	Number of Years	Annual Income

Employer Name	Relationship to Primary Proposed Insured ☐ Spouse ☐ Parent ☐ Other _____

C. Proposed Policy Owner

Complete only if other than the Primary Proposed Insured.

Note: Complete section N for Trust Ownership, Policy Co-Owner (optional) and Successor Policy Owner (optional).

Name of Proposed Policy Owner *(First/Middle/Last/Suffix i.e. Jr., Sr.)*

Primary Telephone Number	Secondary Telephone Number	Primary Language Spoken *(if other than English)*

Relationship to Primary Proposed Insured ☐ Business ☐ Spouse ☐ Parent ☐ Other _____

Gender ☐ Male ☐ Female	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State, Country)*	Taxpayer ID Number or SSN

Address *(Street, City, State, Zip Code)*

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 _____

Face Amount $_____

☐ Non-Nicotine ☐ Nicotine

Accidental Death Benefit $_____

Children's Insurance Rider: _____

☐ First-to-Die Rider *(MPP only)*

☐ Other/Additional Insured Insurance Amount $_____ *(MPP & PWL only)*

☐ Accelerated Benefit Rider for Terminal Illness (*Complete disclosure form, if applicable)*

Farmers Value Term plans only:

☐ Platinum Elite ☐ Platinum Plus

☐ Platinum Choice ☐ Platinum

☐ Gold Plus ☐ Gold

☐ Waiver of Premium

(Can select no more than one of the following)

☐ Critical Illness Accelerated Benefit Rider $ _____ Benefit Amount *(Complete disclosure form and Application Supplement; 20 and 30 year plans only)*

☐ Disability Income Rider $_____ *(Complete Application Supplement)*

Whole Life plans:

☐ 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)*

Single Premium Rider $_____

One-Year Term Rider $_____

Excess Credit Option:

☐ Paid-Up Additions ☐ Reduced Premium

☐ Cash

Traditional Universal Life plans only:

☐ Platinum Elite ☐ Platinum Plus ☐ Platinum Choice ☐ Platinum ☐ Gold Plus ☐ Gold ☐ Juvenile Gold

Variable Universal Life plans only:

☐ Standard Non-Nicotine ☐ Standard Nicotine ☐ Standard Juvenile ☐ Preferred Non-Nicotine ☐ Premier Non-Nicotine

Death Benefit Option *(choose one):*

☐ Increasing/Variable (A) **or** ☐ Level (B)

☐ Automatic Increase Benefit

(Can select no more than one of the following:)

☐ Waiver of Deduction *(adult policy only)*

☐ 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)*

☐ Government Allotment

☐ Other_____

~~☐ Farmers EasyPay *number*_____~~

☐ Folio/Agent Payroll Deduction

☐ FIG/Farmers Employee Deduction

☐ Direct Bill (*select desired frequency)*

☐ Annual ☐ Semi-Annual

☐ 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 in force or application pending on the life of any Proposed Insured? *If "Yes," provide details below.*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
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**

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? ☐ **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 *(Use appropriate "Additional Details" space in section O, if necessary.)*	Primary Proposed Insured	Additional Proposed Insured
1.a. Are you a United States Citizen?	☐ Yes ☐ No	☐ Yes ☐ 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)?	☐ Yes ☐ No	☐ Yes ☐ No
1.d. Visa Type and Expiry date:		
2. 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:***	☐ Yes ☐ No	☐ Yes ☐ 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)? ***If "Yes," provide date(s), type(s) of violation(s), and location (city and state):***	☐ Yes ☐ No	☐ Yes ☐ No
4. 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:***	☐ Yes ☐ No	☐ Yes ☐ 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)? ***If "Yes," complete an aviation questionnaire.***	☐ Yes ☐ No	☐ Yes ☐ 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)? ***If "Yes," complete the applicable questionnaire.***	☐ Yes ☐ No	☐ Yes ☐ No
7. 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:***	☐ Yes ☐ No	☐ Yes ☐ 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? ***If "Yes," provide date(s), type(s) of insurance, final action, and reason(s):***	☐ Yes ☐ No	☐ Yes ☐ 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 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 Acquired Immune Deficiency Syndrome (AIDS) related information by Insurers, I (we) will receive a separate notice regarding the collection and disclosure of 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 _____ (State) on _____ (Month, Day, Year)

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

Signed at _____ (State) 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, 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
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

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.

Fraud Warnings and Other Notices

FARMERS INSURANCE GROUP
FARMERS LIFE INSURANCE

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

Authorization for Release of Health-Related Information to Farmers New World Life Insurance Company
This Authorization complies with the HIPAA Privacy Rule

FARMERS LIFE INSURANCE

_____ ___/___/___

Name of Proposed Insured (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility, or other health care provider ("Providers") to disclose my entire medical record, prescription drug history, and any other health or billing information, including any and all information regarding the diagnosis, treatment or care of any physical or mental condition ("Health Information") concerning me, to Farmers New World Life Insurance Company (FNWL) and its agents, employees, representatives, and reinsurers.

Health Information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Health Information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I am authorizing the Providers to disclose Health Information for the purpose of processing my application for life insurance and, if coverage has been issued, administering the life insurance policy.

By my signature below, I acknowledge that any agreements that I have made to restrict my Health Information do not apply to limit disclosures under this Authorization and I instruct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notice to FNWL. I understand that a revocation is not effective to the extent that any of the Providers has already disclosed information in reliance on this Authorization. I understand that any Health Information that is disclosed pursuant to this Authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the Providers may not refuse to provide treatment, payment for health care services, or enrollment or eligibility for benefits if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Health Information, FNWL may not be able to process my application or, if coverage has been issued, may not be able to make any evaluation or process a claim for benefit payments.

I understand that I am entitled to receive a signed copy of this Authorization.

_____

Signature of Proposed Insured, or Authorized Representative or Parent, if required Date

_____

Description of Representative's Authority to act for the Proposed Insured or Relationship to Proposed Insured

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Variable Policy Service Office: PO Box 724208, Atlanta, GA 31139

California Authorization to Obtain and Disclose Information and Notice of Information Practices

FARMERS LIFE INSURANCE

Farmers New World Life Insurance Company (referred to as FNWL), its reinsurers, insurance support organizations and their authorized representatives, may obtain medical and other information to evaluate my (our) application for life insurance.

I (we) hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Medical Information Bureau (MIB), Inc., the Veteran's Administration, my (our) employer(s) and any consumer reporting agency or insurance company that possess 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) or my (our) children, to furnish such information to FNWL, its reinsurers, and their authorized representatives upon presentation of this Authorization or a photocopy of this Authorization. If your state laws address the collection, use and disclosure of HIV-related information by insurers, you will receive a separate notice regarding the collection, use and disclosure of that information.

A copy of any Investigative Consumer Report obtained by FNWL in connection with your application will be provided to you.

This Authorization will be valid from the date signed for a period of 24 months.

I (we) have read this Authorization to Obtain and Disclose Information, including the following Notice of Information Practices, and have received a copy; my (our) authorized representative is also entitled to receive a copy.

I (we) agree that a photographic copy of this Authorization to Obtain and Disclose Information and Notice of Information Practices shall be as valid as the original.

Dated At: _____ On: _____

_____ _____

Signature of Proposed Insured or Parent if required | Print Name of Proposed Insured

_____ _____

Signature of Additional Proposed Insured | Print Name of Additional Proposed Insured

_____ _____

Signature of Witness (Soliciting Agent) | Print Name of Soliciting Agent

_____

Agent's Number

Farmers New World Life Insurance Company
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Variable Policy Service Office: PO Box 724208, Atlanta, GA 31139 / 1-877-376-8008

Notice of Insurance Information Practices

You have certain rights under state and federal laws. These rights apply to information we collect about you. This data is for personal, family or household insurance. You will receive, or may already have, a "Farmers® Privacy Notice" (FPN). Your state provides other rights explained in this Notice. These rights are not limited by the FPN. This Notice applies to Proposed Insureds and Insureds. It also applies to Policy Owners and former Policy Owners.

Collection of Information

In order to underwrite and administer your policy, we must collect information. This may include personal, financial and health data. The amount and type of data may vary based on the coverage applied for. We may collect data about:

- Your age, occupation, avocations, physical condition and health history.
- Your mode of living and personal traits except as related to your sexual orientation.
- HIV or sexually transmitted disease, nicotine or drug use.
- Prescription drug, drug treatment, alcohol or mental health disorder history.
- Non-medical data, such as motor vehicle and criminal records, may be obtained.

Your Agent may collect data to evaluate and update your insurance. You are the most important source of information. At times we must verify or collect extra data. In those instances, we may contact:

- Medical professionals who have cared for you or your family.
- Employers, business associates, friends and neighbors.
- Other insurance companies where you have applied for insurance.
- Consumer Reporting Agencies (CRA), Insurance Support Organizations (ISO) such as the MIB, Inc.

Data may be collected and transmitted by electronic means. It may also be collected by correspondence, phone or personal contact. A CRA or ISO may be asked to collect data. The CRA or ISO may submit a report to FNWL. You may ask to be interviewed as part of the report. If ordered, the report will be prepared by:

Intellisys
P.O. Box 2340
Lee's Summit, MO 64063

The report may contain:

- Data about your age, occupation and health.
- Your mode of living, avocations and personal traits, except as related to your sexual orientation.

If FNWL obtains a report, we will provide you with a copy. We will tell you who issued the report and how to contact them. You have the right to view your file. You may view the file in person. You may obtain a copy or phone summary upon written request. There may be costs related to your request. These costs will be your responsibility.

Information We Disclose

In some cases, FNWL or your Agent will disclose personal data to third parties. We may disclose information without your consent. This disclosure, as permitted by law, may include:

- Your Agent, in order to service your policy.
- Persons who perform professional, business or insurance functions for FNWL. This may include performing marketing services on our behalf.
- Persons assisting FNWL in determining eligibility for coverage or payment.
- Persons assisting FNWL in detecting or preventing criminal activity in insurance. This may include fraud, material misrepresentation or nondisclosure.
- Persons who conduct actuarial or scientific research studies, audits or evaluations.
- Another insurance company or an ISO to detect/prevent criminal activity/fraud.
- A regulatory, law enforcement or other governmental authority.
- Affiliates, as permitted by law. The law allows us to share your financial information with affiliates to market products or services to you. You cannot prevent these disclosures.
- Non-affiliated third parties, as permitted by law. This includes sharing data to perform joint marketing services, as permitted by law.
- Reports prepared by a CRA or ISO may be retained by that organization. It may be disclosed to others, as allowed by law.

Access and Correction

You can request access to information in your file. This includes any Investigative Consumer Report we have. You may ask to correct, amend or delete data in your file that you believe to be wrong or irrelevant. Access and correction procedures will be sent to you upon request.

Obtaining Additional Information

We take your rights and our responsibilities very seriously. If you have questions, please write to us at the address given.

Farmers New World Life Insurance Company
3003 77th Avenue 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 / 1-877-376-8008

Notice of Insurance Information Practices

You have certain rights under state and federal laws. These rights apply to information we collect about you. This data is for personal, family or household insurance. You will receive, or may already have, a "Farmers® Privacy Notice" (FPN). Your state provides other rights explained in this Notice. These rights are not limited by the FPN. This Notice applies to Proposed Insureds and Insureds. It also applies to Policy Owners and former Policy Owners.

Collection of Information

In order to underwrite and administer your policy, we must collect information. This may include personal, financial and health data. The amount and type of data may vary based on the coverage applied for. We may collect data about:

- Your age, occupation, avocations, physical condition and health history.
- Your mode of living and personal traits except as related to your sexual orientation.
- HIV or sexually transmitted disease, nicotine or drug use.
- Prescription drug, drug treatment, alcohol or mental health disorder history.
- Non-medical data, such as motor vehicle and criminal records, may be obtained.

Your Agent may collect data to evaluate and update your insurance. You are the most important source of information. At times we must verify or collect extra data. In those instances, we may contact:

- Medical professionals who have cared for you or your family.
- Employers, business associates, friends and neighbors.
- Other insurance companies where you have applied for insurance.
- Consumer Reporting Agencies (CRA), Insurance Support Organizations (ISO) such as the MIB, Inc.

Data may be collected and transmitted by electronic means. It may also be collected by correspondence, phone or personal contact. A CRA or ISO may be asked to collect data. The CRA or ISO may submit a report to FNWL. You may ask to be interviewed as part of the report. If ordered, the report will be prepared by:

Intellisys
P.O. Box 2340
Lee's Summit, MO 64063

The report may contain:

- Data about your age, occupation and health.
- Your mode of living, avocations and personal traits, except as related to your sexual orientation.

If FNWL obtains a report, we will provide you with a copy. We will tell you who issued the report and how to contact them. You have the right to view your file. You may view the file in person. You may obtain a copy or phone summary upon written request. There may be costs related to your request. These costs will be your responsibility.

Information We Disclose

In some cases, FNWL or your Agent will disclose personal data to third parties. We may disclose information without your consent. This disclosure, as permitted by law, may include:

- Your Agent, in order to service your policy.
- Persons who perform professional, business or insurance functions for FNWL. This may include performing marketing services on our behalf.
- Persons assisting FNWL in determining eligibility for coverage or payment.
- Persons assisting FNWL in detecting or preventing criminal activity in insurance. This may include fraud, material misrepresentation or nondisclosure.
- Persons who conduct actuarial or scientific research studies, audits or evaluations.
- Another insurance company or an ISO to detect/prevent criminal activity/fraud.
- A regulatory, law enforcement or other governmental authority.
- Affiliates, as permitted by law. The law allows us to share your financial information with affiliates to market products or services to you. You cannot prevent these disclosures.
- Non-affiliated third parties, as permitted by law. This includes sharing data to perform joint marketing services, as permitted by law.
- Reports prepared by a CRA or ISO may be retained by that organization. It may be disclosed to others, as allowed by law.

Access and Correction

You can request access to information in your file. This includes any Investigative Consumer Report we have. You may ask to correct, amend or delete data in your file that you believe to be wrong or irrelevant. Access and correction procedures will be sent to you upon request.

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We take your rights and our responsibilities very seriously. If you have questions, please write to us at the address given.

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State Of California
Notice and Consent for Blood and/or Other Bodily Fluid Testing Which May Include HIV Antibody/Antigen Testing

FARMERS INSURANCE GROUP
Symbol of Superior Service

FARMERS LIFE INSURANCE

To determine your insurability, the insurer named above, Farmers New World Life Insurance Company, may request that you provide a sample of your blood or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory selected by the insurer at no cost to you. The consent you give by signing this form authorizes the insurer to obtain a sample of your blood, oral fluid or other bodily fluid and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that is performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Occasionally, however, false results may occur. A false positive is very rare, and is most common in persons who have not engaged in high risk behavior. False negative results occur most commonly in recently infected persons; it takes 4-12 weeks for a positive result to develop after a person is infected. Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders, and the presence of nicotine, certain prescription medications and drugs of abuse.

No adverse underwriting decision will be made on the basis of reactive HIV-related tests unless based on an approved testing protocol including, but not limited to, two reactive enzyme-linked immunosorbent assays (ELISA) tests, followed by confirmatory Western Blot Testing.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If a sample of your bodily fluid is tested to determine the presence of HIV, the insurer may at a later time request a specimen of your blood for further HIV testing. All abnormal test results for HIV antibodies/antigens will be reported to MIB, Inc., by a generic code which signifies only a non-specific test abnormality. If the HIV test is normal, no report will be made about it to the MIB, Inc. Other non HIV-related test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you, including but not limited to the release of information to the Department of Health Services as may be provided by law. The testing laboratory and/or insurer may also be required to report positive tests for other communicable diseases, such as Hepatitis B and C, to the Department of Health Services. The Department of Health Services may contact you about your results, if positive.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. Reactive (positive) HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. Reactive (positive) HIV antibody or antigen test results or other significant blood or other bodily fluid abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this **Notice and Consent for Blood and/or Other Bodily Fluid Testing Which May Include HIV Antibody/Antigen Testing.** I voluntarily submit a bodily fluid specimen and/or consent to the withdrawal of blood from me by needle, the testing of that blood or bodily fluid, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Proposed Insured | Date of Birth

I authorize the release of my test results, which may include positive or abnormal HIV, Hepatitis B and/or Hepatitis C results, to my physician, Health Care Provider or Health Care Agency:

_____

_____

Name and Address of Physician, Health Care Provider or Agency

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

Farmers New World Life Insurance Company
3003 77th Avenue 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

Original to FNWL/Copy to Proposed Insured

HIV Information Form for Insurance Applicant

About AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood, (as in needle sharing during IV drug use).

AIDS does not typically develop until a person has been infected with HIV virus for several years. A person may remain free of symptoms for years after becoming infected. Symptoms of infection may include fever, weight loss for no apparent reason, swollen lymph glands, fatigue, diarrhea, or white spots or blemishes in the mouth.

HIV Testing and Results

There are tests that determine the presence of antibodies or antigens to HIV. These tests do not test for AIDS; AIDS can only be diagnosed by medical evaluation.

A positive test result means that person is infected with HIV.

A person with positive test should:

- Have a regular medical check-up and get counseling.
- Not donate blood, sperm or organs.
- Not share needles with others.
- Avoid exchanging body fluids during sexual activity.
- Not share toothbrushes, razors or anything that could be contaminated with blood.

A negative test result is not a guarantee that person is not infected. It takes several weeks for a positive test result to develop after a person is infected. Persons with a negative test result should begin, or continue, to practice safe sex, (including condom use for sexual contact with someone other than a long-term monogamous partner) and not engage in high risk behavior, such as sharing needles.

Information and Counseling Resources

Further information about HIV testing and AIDS can be obtained by calling one of the following AIDS hotlines:

California 1-800-367-2437
National AIDS Hotline 1-800-232-4636

AIDS counseling is available at these and other locations:

San Francisco AIDS Foundation
1035 Market Street, Suite 400
San Francisco, CA 94103
(415) 487-3000

AIDS Project Los Angeles
611 South Kingsley Drive
Los Angeles, CA 90005
213-201-1600
Info@apla.org

State Of California
Notice and Consent for Blood and/or Other Bodily Fluid Testing Which May Include HIV Antibody/Antigen Testing

FARMERS INSURANCE GROUP
Symbol of Superior Service

FARMERS LIFE INSURANCE

To determine your insurability, the insurer named above, Farmers New World Life Insurance Company, may request that you provide a sample of your blood or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory selected by the insurer at no cost to you. The consent you give by signing this form authorizes the insurer to obtain a sample of your blood, oral fluid or other bodily fluid and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that is performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Occasionally, however, false results may occur. A false positive is very rare, and is most common in persons who have not engaged in high risk behavior. False negative results occur most commonly in recently infected persons; it takes 4-12 weeks for a positive result to develop after a person is infected. Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders, and the presence of nicotine, certain prescription medications and drugs of abuse.

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All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If a sample of your bodily fluid is tested to determine the presence of HIV, the insurer may at a later time request a specimen of your blood for further HIV testing. All abnormal test results for HIV antibodies/antigens will be reported to MIB, Inc., by a generic code which signifies only a non-specific test abnormality. If the HIV test is normal, no report will be made about it to the MIB, Inc. Other non HIV-related test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you, including but not limited to the release of information to the Department of Health Services as may be provided by law. The testing laboratory and/or insurer may also be required to report positive tests for other communicable diseases, such as Hepatitis B and C, to the Department of Health Services. The Department of Health Services may contact you about your results, if positive.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. Reactive (positive) HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. Reactive (positive) HIV antibody or antigen test results or other significant blood or other bodily fluid abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

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_____ _____

Proposed Insured | Date of Birth

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_____

_____

Name and Address of Physician, Health Care Provider or Agency

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

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HIV Information Form for Insurance Applicant

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San Francisco, CA 94103
(415) 487-3000

AIDS Project Los Angeles
611 South Kingsley Drive
Los Angeles, CA 90005
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Info@apla.org

Electronic Funds Transfer (EFT) Authorization

FARMERS INSURANCE GROUP
FARMERS LIFE INSURANCE

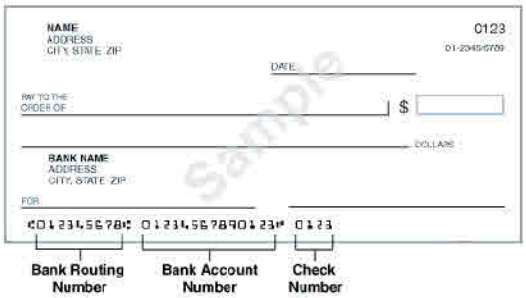
Important: Prior to completing this form please read the Information regarding EFT transactions on page two.

Policy Number(s): _____

Insured(s) Name _____

Account Holder's Name: _____
(Please Print Clearly)

Name of Financial Institution _____



Type of Account: ☐ **Individual** ☐ **Business**
Choose one ☐ **Checking** ☐ **Savings**

Bank Routing Number | Bank Account Number | Check Number

⑆ | | | | | | | | | ⑆ | | | | | | | | | | | | | | | | | | | | | ⑈ | | | | | | |

Street Address | City | State | ZIP Code

Is this a new address? ☐ Yes ☐ No Requested monthly draft date: _____ (Please select a draft date between 1-28.)

Note: We will draft any day of the month between the 1st and 28th. If you request a draft date more than 10 days after the policy anniversary day, the draft will occur before, not after the premium is due.

I authorize Farmers New World Life Insurance Company (the Company) to initiate electronic funds transfer (EFT) withdrawals, by debiting my account indicated above. I authorize my financial institution to pay and charge such amounts to my account. I understand that if, at any time, I change financial institutions and/or accounts, a new form will need to be submitted. I agree that the Company's rights in regard to each such withdrawal shall be the same as if it were a check written to the Company and signed personally by me. This authority is to remain in effect until the Company has received appropriate notice of its termination, in such time and manner as to afford the Company a reasonable opportunity to act upon it.

I understand and agree the Company shall be fully protected in honoring any such withdrawal. I understand and agree that in the event any such withdrawal returned by my financial institution, whether with or without cause and whether intentionally or inadvertently, the Company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. I understand and agree the Company, at its discretion, may make or discontinue withdrawals from my account while this authorization is in effect. In the event of a dishonored draft for "Non-Sufficient Funds," a replacement draft may be submitted to the account. In addition, I understand it's my responsibility to assure payments are being withdrawn.

Signature of Authorized Account Holder (as it appears on account) | Relationship to Insured/Annuitant | 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 1-877-376-8008

Original to FNWL / Copy to Customer

Information regarding Electronic Funds Transfer

- **How Does EFT Work?**

EFT allows you to have your life insurance premiums and/or your annuity contributions electronically transferred to us each due date directly from your financial institution without you having to write checks or mail in payments.
Every month, on your monthly premium due date, we will electronically withdraw the monthly payment from your financial institution for your policy(ies) stated on the EFT Authorization form your authorization remains in effect. Premiums with a due date falling on a Saturday, Sunday or Company holiday will be released the following business day. If you prefer EFT withdrawals on a date other than your premium due date, you may specify a draft date between the 1st and 28th of the month in the space provided on the authorization form.

- **How Do I Request EFT Billing?**

Complete the Electronic Funds Transfer Authorization form ***providing the full Bank Routing and Account Number and submit it to our office for processing.*** A new form is required each time your financial institution information changes.

- **What if I have multiple policies?**

Only those policies listed on the EFT Authorization form will be established on EFT. Unless you request otherwise, multiple policies drafting on the same draft day from the same bank account will be combined and appear on your bank statement as one debit and reflect the total premium for all policies. If you are changing bank accounts, we will assume that any policy number currently billing on EFT not listed on the form will continue to draft from the prior bank account as that authorization remains in effect. We are not responsible for any policy not listed that enters the grace period and lapses for non-payment of premium.

- **What if I Change My Bank Account?**

If you change accounts or banks, please provide us with a new EFT Authorization form thirty (30) days in advance of the change. ***We recommend you leave sufficient funds in your old bank account to cover premiums until we begin drafting your new bank account and/or you receive notification that we have completed the change.*** Reimbursement of overdraft charges will not be considered if they are incurred within 30 days of requesting a change in bank accounts or not communicated with our office.

- **What if an EFT Withdrawal is Not Honored by my Bank?**

An EFT withdrawal not honored for a reason other than insufficient funds will be returned to FNWL after being presented once to your bank. An EFT withdrawal not honored for insufficient funds will be presented by the clearing bank a second time before it is returned to FNWL. Upon receipt of a returned EFT withdrawal, you will be removed from EFT billing method and placed on direct billing. Any premium payment applied to your policy(s) in good faith will be reversed and your policy could enter its grace period.

- **Who Should I Contact to Discontinue EFT?**

You or your Farmers agent should call our office. You may also request this in writing. The authority to electronically withdraw will remain in effect until the Company receives appropriate notice of its termination. We would like notification received in our office ***10 business days*** prior to your EFT withdrawal due date to allow us enough time to process your request unless your contract states otherwise.

- **Other Important Information**

If there are changes made to your coverage on any policy billing on EFT, your EFT premium withdrawal may also change as the premium changes. Please contact your Farmers agent or our Customer Service Line provided below if you need to stop the EFT withdrawal for that premium payment ***no less than 10 business days*** before the premium draft date. ***We are not responsible for any overdraft fees to your bank account if we are not notified to stop the draft in a timely manner.*** Any premium refunds due on this policy will be made payable to the Policy Owner.