

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.)

The Proposed Insured does not have to disclose a bloodborne pathogen test which was administered to a crime victim, criminal offender, inmate or corrections employee, patient or employee of a secure treatment facility, or emergency medical personnel. The term "emergency medical personnel" includes individuals employed to provide emergency medical services, such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individuals who serve as an employee or volunteer of an ambulance service, or a member of an organized first responder squad who provides emergency medical services, licensed peace officers, crime lab personnel, and individual who renders emergency care at the scene of an emergency who is acting under the good Samaritan law, or an individual who, in the process of executing a citizen's arrest, may have experienced significant exposure to an individual who may be a source of bloodborne pathogens.

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:
  - 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? .....  Yes  No
5. Have you ever been diagnosed by a medical professional with, or received treatment for Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), or other immune disorder? .....  Yes  No
6. Have you, in the past five years, used or been treated for the use of cocaine, marijuana, heroin, or any other addictive or illegal drugs .....  Yes  No
7. Have you, in the past five years, 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 medically advised to be admitted to any hospital or health care facility; or undergone or been medically advised to have surgery, biopsies, treatment or medical tests that are not included in your answers to any of the preceding questions? .....  Yes  No
11. Have you been treated or diagnosed with 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 \_\_\_\_\_

**APPS Para Medical Services**  
3025 Harbor Lane, Suite  
Plymouth, MN 55447-5141  
Billed By APPS-Jerlco, NY  
TAX ID# 112298722

Name of Examiner (please print or type)

Name of Firm

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

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

b. What language was used? \_\_\_\_\_

**Farmers New World Life Insurance Company**  
**Overflow Addendum**

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**Proposed Insured Name:****Policy Number:**

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**Additional Details Continued:**

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

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**Proposed Insured Signature** (or parent if Proposed Insured is a juvenile)Signed at \_\_\_\_\_  
Stateon \_\_\_\_\_  
Month, Day, Year

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**Proposed Policy Owner Signature** (if other than Proposed Insured)\_\_\_\_\_  
State\_\_\_\_\_  
Month, Day, Year

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**Agent or Witness Signature** (if present)

# Fraud Warnings and Other Notices



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Farmers New World Life Insurance Company

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