



New Business Change Request – Application Amendment

Primary Proposed Insured: Heather Gustafson Policy Number: 002948632

A Proposed Insured(s) Change(s)

Primary Proposed Insured

- Change Name to: _____
Full Legal Name (First, Middle, Last, Suffix)
- Change DOB to: _____
(mm/dd/yyyy)
- Change US Driver's License # to: _____
(Attach copy of Driver's License)

Additional Proposed Insured

- Change Name to: _____
Full Legal Name (First, Middle, Last, Suffix)
- Change DOB to: _____
(mm/dd/yyyy)
- Change US Driver's License # to: _____
(Attach copy of Driver's License)

B General Change(s)

See section C for other plan specific changes

- Change Face Amount to: \$ 150,000
(Increase in Face Amount may require additional medical requirements. Consult Minimum Underwriting Requirements chart.)
 - Change Rate Class to:

<p><u>Non-Nicotine</u></p> <p>FEUL/IUL/VT: <input type="checkbox"/> Platinum <input type="checkbox"/> Platinum Choice <input type="checkbox"/> Platinum Plus <input type="checkbox"/> Platinum Elite</p> <p>FELVUL: <input type="checkbox"/> Standard <input type="checkbox"/> Preferred <input type="checkbox"/> Premier</p> <p>ST/FESWL: <input type="checkbox"/> Select (Special-WA) <input type="checkbox"/> Select Plus</p> <p>FDT(MPP)/PWL: <input type="checkbox"/> Non-Nicotine</p>	<p><u>Nicotine</u></p> <p><input type="checkbox"/> Gold <input type="checkbox"/> Gold Plus</p> <p><input type="checkbox"/> Standard</p> <p><input type="checkbox"/> Select (Special-WA)</p> <p><input type="checkbox"/> Nicotine</p>
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 - Add Remove – Accelerated Benefit Rider – Terminal Illness (PA residents: Terminal Condition)
 - Add Remove Change Amount – Accidental Death Benefit \$ _____
 - Add Remove Change Amount – Children's Term Insurance Rider \$ _____
 - Add Remove Change Amount – Other/Additional Insured Insurance \$ _____
- (Evidence of insurability may be required for adding any Additional Proposed Insured(s).)

C Plan Specific Change(s)

Variable or Universal Life Plans

- Change to: Plan: _____ with a Death Benefit Option of: Increasing/Variable or Level, and
(plan name or code number)
a Planned Premium of: \$ _____ (Plan changes to Variable or IUL product; also complete appropriate Application Supplement)
- Change only to: Death Benefit Option Increasing/Variable Level
- Add Remove – Automatic Increase Benefit
- Add* Remove – Chronic Illness Rider (*Also complete Disclosure form) (Available only if ABR-TI is present.)
(No more than one of the following are available at a time)
- Add Remove – Waiver of Deduction
- Add Remove – Owner Waiver of Deduction

C Plan Specific Change(s) (continued)

Term Plans

1. Change to: Term Plan: _____ in the Length of: _____ Years
(plan name or code number)
2. Change only to: Length of Term: 10 Years
3. Add Remove – Waiver of Premium
4. Add* Remove Change Amount – Critical Illness – Accelerated Benefit Rider \$ _____ (VT 20 & 30 year only)
(*Also complete Disclosure form and Application Supplement) (CI-ABR not available in all states)

Whole Life Plans

1. Change to: Whole Life Plan: _____
(plan name or code number)
2. Add Remove – Non-forfeiture Options:
 - Automatic Premium Loan
 - Extended Term Insurance
 - Reduced Paid-Up Insurance
3. Add Remove – Excess Credit Option:
 - Cash
 - Paid-Up Additions
 - Reduced Premium
4. Add Remove – Waiver of Premium
5. Add Remove – Owner Waiver of Premium/Payor Benefits
6. Add Remove Change Amount – Guaranteed Insurability Benefit \$ _____
7. Add Remove Change Amount – Single Premium Rider \$ _____
8. Add Remove Change Amount – One-Year Term Rider \$ _____

D Rated Policy

I (We) accept the policy issued with:

1. Table rating of: _____
2. Permanent Flat Extra Rate of: _____ per thousand.
3. Temporary Flat Extra Rate of: _____ per thousand for _____ years.

E Other Contractual Change Request

1. Other Contractual Change Request: _____
Approve Platinum Table D due to treatment for ADD and information found in medical records

F Acknowledgement & Authorization Signatures

Complete this section for all cases

I (We) understand that portions or all of the data collected to create this New Business Change Request - Application Amendment (Amendment), 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 copy of this Amendment, which will become part of the Policy Contract, if issued or upon receipt of a written request directed to Farmers New World Life Insurance Company.

I (We) represent that since the completion of the original application, the health of all Proposed Insureds has remained unchanged and none of the Proposed Insureds have consulted with nor been treated by a physician or medical practitioner for any cause other than the insurance medical exam, if any. If any person to be insured under the policy is unable to attest to the foregoing health statement, this document cannot be signed and the policy cannot be delivered or placed in force.

I (We) have read the completed Amendment, or have had it read to me, and agree that all the statements and answers are true and complete to the best of my knowledge and belief; and will be relied upon to determine my insurability.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

DocuSigned by:
Signature of Proposed Insured(s) – (or Parent/Legal Guardian if Primary Insured is a juvenile and if other than Policy Owner)
 X Heather Gustafson 8/19/2021 X _____
Primary Insured Date Additional Insured (if applicable) Date

X _____
Parent/Legal Guardian Date

Signature of Proposed Policy Owner(s) – (if other than Proposed Insured(s))
 X _____ X _____
Policy Owner (if applicable) Date Policy Co-Owner (if applicable) Date

DocuSigned by:
Signature of Insurance Producer
 X [Signature] 1380s11 08/03/2021 8/3/2021
Insurance Producer Agent Code Number Date