Farm Bureau Life Insurance Company
5400 University Avenue
West Des Moines, Iowa
50266-5997

FARM BUREAU FINANCIAL SERVICES

LIFE APPLICATION

Policy # (Home Office Use Only)

Agent Information: Name	State-County	Phone #	Agent #	%	Account #
#1					
#2					**Applicant's St-Cty**
#3					

All references to "the Company" shall mean Farm Bureau Life Insurance Company of West Des Moines, Iowa.

SECTION A – APPLICATION FOR LIFE INSURANCE

INDICATE TYPE OF CASE AND COMPLETE THE NECESSARY SECTION(S).

TYPE OF APPLICATION	COMPLETE THESE SECTIONS
☐ **New Business**	
☐ Regular New Business ☐ Preliminary Trust ☐ Trial Application (Do not submit premium) ☐ Replacement of Policy #(s) _____	Sections B, C, D, E, F, G & Authorization Supplements 1-4 (if applicable) EFT (if applicable) Agent's Certificate Temporary Insurance Agreement
☐ Teleunderwriting (See EasyApp instructions)	As above, except F & G not required
☐ **Contractual Conversion**	
Of Term Rider or Policy # _____ ☐ Issue new Policy or ☐ Increase UL/VUL # _____ Remaining coverage (if any) to be: ☐ Continued ☐ Terminated ☐ Rider on new Policy If the current term rider or Policy has a Waiver of Premium Rider and it is being applied for on the new Policy, is the Proposed Insured now totally disabled as defined in the rider? ☐ Yes ☐ No	Sections B, C, E & Authorization EFT (if applicable) Temporary Insurance Agreement If additional coverage applied for, see New Business above
☐ **Guaranteed Purchase Option/Guaranteed Insurability Option**	
From Policy # _____ ☐ Exercise GPO ☐ Exercise GIO to increase UL/VUL Policy by $ _____	Sections B, C, E & Authorization EFT (if applicable)
☐ **Policy Change**	
On Policy #_____ ☐ Increase UL/VUL/LSVUL/LSUL Policy by $_____ ☐ Change to Non-Tobacco rates ☐ Change to Preferred/Super Preferred rates ☐ Add Waiver of Premium/Waiver of Charges ☐ Reconsider rating or exclusion rider (give details) _____ _____ ☐ Other (be specific) _____ _____	Section B – Proposed Insureds 1 & 2 Sections F, G & Authorization Supplements 1-4 (if applicable) On all Increases, also complete: Section C – Plan & Amount Section D Temporary Insurance Agreement
☐ **Reinstatement**	
Of Policy #(s) _____	Section B – Proposed Insureds 1 & 2 Sections F, G & Authorization EFT (if applicable)

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.

SECTION B – PERSONAL INFORMATION

PROPOSED INSURED 1 - ☐ **TOBACCO** ☐ **NON-TOBACCO**

1a. Complete Name (first-middle-last)	1b. List any other names used in the past

2a. Sex	2b. Age	2c. Birth Date	2d. Birth State	2e. Social Security #	2f. Driver's License # / State	2g. Citizenship ☐ US ☐ _____

3a. Residence Address	3b. City	3c. State	3d. ZIP

4. List all phone numbers where we can contact you for an interview	4a. Home Phone	4b. Work Phone	4c. Cell or Other

5a. Job Title/Duties	5b. Employer Name

6a. Annual earned income - Gross	6b. Net Worth

PROPOSED INSURED 2 – (FOR JOINT OR TERM RIDERS ONLY) ☐ **TOBACCO** ☐ **NON-TOBACCO**

7a. Complete Name (first-middle-last)	7b. List any other names used in the past

8a. Sex	8b. Age	8c. Birth Date	8d. Birth State	8e. Social Security #	8f. Driver's License # / State	8g. Citizenship ☐ US ☐ _____

9a. Residence Address	9b. City	9c. State	9d. ZIP

10. List all phone numbers where we can contact you for an interview	10a. Home Phone	10b. Work Phone	10c. Cell or Other

11a. Job Title/Duties	11b. Employer Name

12a. Annual earned income - Gross	12b. Net Worth

OWNER: (IF OTHER THAN PROPOSED INSURED 1)

13a. Owner Name(s) (first-middle-last)*	13b. Relationship(s)	13c. Birth Date	13d. SS#/TIN(s)	13e. Citizenship ☐ US ☐ _____

14a. Residence Address	14b. City	14c. State	14d. ZIP

15a. Contingent Owner Name (and address if other than #14)	15b. Relationship(s)	15c. Birth Date	15d. SS#/TIN(s)	15e. Citizenship ☐ US ☐ _____

*Multiple owners will be deemed to be joint tenants with full rights of survivorship unless otherwise specified.

PAYOR: (IF OTHER THAN PROPOSED INSURED 1 OR OWNER)

16a. Payor Name (first-middle-last)	16b. Birth Date	16c. SS#/TIN	16d. Citizenship ☐ US ☐ _____

17a. Residence Address	17b. City	17c. State	17d. ZIP

CHILDREN PROPOSED FOR INSURANCE ON CHILD RIDER (AGE 17 YEARS AND YOUNGER)

18. CHILDREN (LIST NAMES BELOW: FIRST-MIDDLE-LAST)	SEX	AGE	BIRTH DATE	BIRTH STATE	HEIGHT / WEIGHT	AMOUNT OF LIFE INSURANCE IN FORCE
					ft in lbs	
					ft in lbs	
					ft in lbs	
					ft in lbs	

19. Are all children listed the natural or legally adopted children of the Proposed Insured or Spouse? ☐ Yes ☐ No

20. Has each child eligible for coverage been included? ☐ Yes ☐ No

21. Is the residence of Proposed Insured 1 the permanent residence of all children listed? ☐ Yes ☐ No

22. If #19-21 answered "No", provide details here.

SECTION C - LIFE INSURANCE APPLIED FOR:

1. UNIVERSAL LIFE, VARIABLE UNIVERSAL LIFE, LAST SURVIVOR VARIABLE UNIVERSAL LIFE	2. TERM	3. WHOLE LIFE, LAST SURVIVOR WHOLE LIFE
a. Plan _____	a. Plan ☐ Value Premium Plan ☐ Guaranteed Premium Plan	a. Plan _____
b. Amount $ _____	b. Amount $ _____	b. Amount $ _____
c. Death benefit option ☐ Increasing – A ☐ Level – B	c. Select Term ☐ 1 yr. ☐ 10 yrs. ☐ 15 yrs. ☐ 20 yrs. ☐ 30 yrs.	c. Dividend option, if participating ☐ Pay by check ☐ Apply to Reduce Premium ☐ Leave to Accumulate ☐ Buy Paid-Up Insurance Additions ☐ Other _____
d. Billed premium amount $ _____	d. ☐ Guaranteed Re-entry $_____	
e. Check box if **NO** billings are to be sent: ☐	e. ☐ Other _____	d. ☐ Other _____
f. **If applying for Variable, complete Form 432-138/Variable Supplement and 732-021/CAR**	f. ☐ Other _____	

LIFE RIDERS FOR UL/VUL/LSVUL INSURANCE:

4. ☐ U-Term – Proposed Insured 1 (UL/VUL).
   Amount $ _____ Select Term ☐ 10 ☐ 15 ☐ 20 ☐ 30 yrs.
5. ☐ U-Term – Proposed Insured 2 (UL/VUL).
   Amount $ _____ Select Term ☐ 10 ☐ 15 ☐ 20 ☐ 30 yrs.
6. ☐ Universal Children's Term (UL/VUL)
   Amount $ _____
7. ☐ Universal Term – Proposed Insured 1 (LSVUL)
   Amount $ _____
8. ☐ Universal Term – Proposed Insured 2 (LSVUL)
   Amount $ _____
9. ☐ Estate Protector (LSVUL)
   Amount $ _____
10. ☐ Guaranteed Insurability Option (UL/VUL)
    Amount $ _____
11. ☐ Waiver of Charges
12. ☐ Cost of Living Increase
13. ☐ Death Benefit Guarantee (VUL/LSVUL)
14. ☐ Other – Be specific _____
15. ☐ Other – Be specific _____

LIFE RIDERS FOR WHOLE LIFE/TERM INSURANCE:

16. ☐ Waiver of Premium
17. ☐ Payor Death or Disability
18. ☐ Children's Term
    Amount $ _____
19. ☐ Choice Term – Proposed Insured 1
    Amount $ _____ Select Term ☐ 10 ☐ 15 ☐ 20 ☐ 30 yrs.
20. ☐ Choice Term – Proposed Insured 2
    Amount $ _____ Select Term ☐ 10 ☐ 15 ☐ 20 ☐ 30 yrs.
21. ☐ Guaranteed Purchase Option
    Amount $ _____
22. ☐ Paid-Up Additions Rider
    ☐ Dump-in Premium $_____
    ☐ Annual Premium $ _____
    Premium-Paying Period _____ years
23. ☐ Balanced Term Rider
    Amount $_____
24. ☐ Other – Be specific _____
    Amount (if applicable) $ _____
25. ☐ Other – Be specific _____
26. ☐ Other – Be specific _____

LIFE PREMIUMS:

27. Method: ☐ EFT ☐ Salary Savings ☐ Direct ☐ Advance Prems. $_____ Years _____
28. Frequency: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (not available on Direct)
29. EFT start date _____
30. Submitted premium (not including transfer) $ _____
31. Transfer funds from Pol. #_____ $_____ (Submit Policy Service Request Form)
32. Anticipated Value of 1035 Exchange or Dump-in Amount $_____
33. Billing address, if other than Residence Address _____

SECTION D – EXISTING COVERAGE/REPLACEMENT

1. Does either the Owner or Proposed Insured have any other life insurance policies or annuity contracts? ☐ Yes ☐ No
   If "Yes" and required by your state, complete 434-176/Important Notice

2. Is the Policy applied for replacing or likely to replace any existing life or annuity policy? ☐ Yes ☐ No
   If "Yes", indicate replacement by placing an "R" for that policy in the last column

3. Are values for an existing life insurance policy or annuity being used to pay premiums on the new Policy? ☐ Yes ☐ No
   If "Yes", indicate by placing an "F" (financed purchase) for that policy in the last column

4. If 2 or 3 is "Yes", provide the reason for this replacement/financed purchase:

If Question 1 is "Yes", complete the table below.

OWNER "O" INSURED "I" NAME	INDICATE "O" OR "I"	COMPANY NAME AND ADDRESS	POLICY NUMBER	TYPE OF POLICY AND AMOUNT	INDICATE "R" OR "F"

The following are commonly exempt from replacement regulations:
an application to exercise a contractual change or conversion privilege on a policy issued by the Company
an application replacing only life insurance existing under a temporary insurance agreement by the Company.

SPECIAL REQUESTS:

Unless otherwise indicated, these options apply:
I request the adjustable policy loan interest rate.
I request the Automatic Premium Loan Privilege, if available.

ADMINISTRATIVE/HOME OFFICE ENDORSEMENTS (HOME OFFICE USE ONLY):

SECTION E – BENEFICIARY

1. BASE POLICY

Check and complete only one of the items labeled a-f for the Beneficiary of the base Policy

a. ☐ **PRIMARY BENEFICIARY(IES) – In equal shares to each who survive the Insured:**

Full Name	Address, if other than shown in B - 3a	SS#/TIN	Relationship to Insured

If no such Beneficiary survives the Insured then to the following Contingent Beneficiary(ies):

CONTINGENT BENEFICIARY(IES) – In equal shares to each who survive the Insured:

Full Name	Address, if other than shown in B - 3a	SS#/TIN	Relationship to Insured

b. ☐ **SPOUSE PRIMARY BENEFICIARY – CHILDREN CONTINGENT BENEFICIARY – PER CAPITA**

_____ , Spouse of Insured, if living, otherwise equally to the surviving children of the Insured.

c. ☐ **SPOUSE PRIMARY BENEFICIARY – CHILDREN CONTINGENT BENEFICIARY – PER STIRPES**

_____ , Spouse of Insured, if living, otherwise to the children of the Insured, share and share alike, except that if any such child be not living to receive any share of the proceeds apportioned to such child, the share of such deceased child's proceeds shall be paid in one sum to the surviving children of such child, if any, in equal shares, otherwise to such of the children of the Insured as may be then living, in equal shares.

d. ☐ **LIVING TRUST AS PRIMARY BENEFICIARY**

_____ , Trustee(s) or any successor trustee(s) under written agreement
Name of Trustee(s)

created by _____
Name of Grantors

named _____ Dated _____ , and any amendments made
Name of Trust Month/Day/Year

thereto, or if the trust is terminated or the Company is not furnished evidence of the qualifications of such Trust within 365 days of the death of the Insured, to the Estate of the Insured.

e. ☐ **TESTAMENTARY TRUST AS PRIMARY BENEFICIARY**

Trustee(s) or any successors in trust under the Last Will of the Insured or any codicils thereto.

f. ☐ **INSURED'S ESTATE – THE PERSONAL REPRESENTATIVE OF THE INSURED**

2. RIDER BENEFICIARIES

a. For proceeds of riders payable upon the death of Proposed Insured 1

Full Name	Address, if other than shown in B - 3a	SS#/TIN	Relationship to Insured

b. For proceeds of riders payable upon the death of Proposed Insured 2

Full Name	Address, if other than shown in B - 9a	SS#/TIN	Relationship to Insured

If no Beneficiary is specified: For proceeds payable under Children's Term riders, the Beneficiary will be the Owner, if living, otherwise the Owner's estate; for proceeds payable under the Estate Protector rider, the Beneficiary will be as shown for Base Policy.

3. COMMON DISASTER PROVISION

It is understood and agreed that the following Common Disaster provision shall be effective only if checked or marked with an "X" and the number of days inserted in the space provided.

☐ **COMMON DISASTER:** If any Beneficiary shall die simultaneously with the Insured or within _____ (not to exceed 30) days after the death of the Insured, payment of the proceeds shall be made in accordance with the Policy terms and conditions which would have prevailed had the Insured survived such Beneficiary.

Complete for all Proposed Insureds - Including children on term riders

SECTION F – GENERAL QUESTIONS

Has any person proposed for coverage:	**YES**	**NO**
1. Ever had an application for insurance or reinstatement postponed, rated, canceled, refused or declined?	☐	☐
2. Applied for any life insurance that is still pending?	☐	☐
3. Been in bankruptcy proceedings that are still pending?	☐	☐
4. Lived or traveled outside the U.S. and Canada within the past 12 months or plan to in the next 12 months?	☐	☐
5. Had any present or expected military service in the Armed Forces, Reserves, or National Guard?	☐	☐
6. Been exempted, rejected or discharged by the Armed Forces, Reserves, or National Guard?	☐	☐
7. Ever sought or received advice or treatment for use of alcohol? **(If "Yes", complete Supplement 1 – Alcohol.)**	☐	☐
8. Used or received advice or treatment for any narcotic, stimulant, sedative, hallucinogenic, or habit-forming drug? **(If "Yes", complete Supplement 2 – Drug.)**	☐	☐
9. Flown as a pilot, crew member or student pilot within the past 2 years or plan to fly as a pilot, crew member or student pilot in the future? **(If "Yes", complete Supplement 3 – Aviation.)**	☐	☐
10. Within the past two years engaged in or plan to engage in rodeo events, racing, hang gliding, skin/scuba diving, or other avocations? **(If "Yes", complete Supplement 4 - Sports/Rodeo/Avocations.)**	☐	☐
11. Been convicted of, or awaiting trial for, any crime other than a misdemeanor?	☐	☐
12. Used nicotine or tobacco in any form within the past three years?	☐	☐
☐ Current use: Form and amount per day _____		
☐ Not current, but within past three years: Date of most recent use _____ Form and amount per day _____		
13. Had a driver's license suspended or revoked or had two or more moving violations or two or more motor vehicle accidents within the past three years?	☐	☐
14. Had a conviction for DUI/DWI or reckless driving within the past five years?	☐	☐

Details to each "Yes" answer -- Identify question #, person and give complete details.

15. Name, address and phone number of regular doctor. (If none, state "None".) Date and reason last seen.

Proposed Insured 1

Doctor _____ Phone # _____
Name and address

Reason last seen _____ Date last seen

Proposed Insured 2

Doctor _____ Phone # _____
Name and address

Reason last seen _____ Date last seen

Child

Doctor _____ Phone # _____
Name and address

Reason last seen _____ Date last seen

Child

Doctor _____ Phone # _____
Name and address

Reason last seen _____ Date last seen

Complete for all Proposed Insureds - Including children on term riders

SECTION G - MEDICAL QUESTIONS

Details to each "Yes" answer -- Identify question # and person. Circle specific condition, give date, duration, degree of recovery and name, address and phone number of physicians/hospitals.

1. **Height and weight - Proposed Insured 1:** ft_____ in____ lbs_____

2. **Height and weight - Proposed Insured 2:** ft_____ in____ lbs_____

3. **Has any person proposed for coverage had or been told they have or had:**	YES	NO
A. Epilepsy, convulsions, paralysis, severe headaches, mental illness, or other disorders of the brain or nervous system?	☐	☐
B. Chest pain, heart attack, heart murmur, high blood pressure, palpitation, stroke, or other disorders of the heart or circulatory system?	☐	☐
C. Asthma, emphysema, tuberculosis or other disorders of the lungs, bronchial tubes, throat or respiratory system?	☐	☐
D. Ulcer, intestinal bleeding, colitis, hernia, hepatitis, or other disorders of the stomach, intestines, liver or gall bladder?	☐	☐
E. Kidney stone, nephritis, blood or sugar in the urine or other disorders of the kidney, urinary system, breasts or genital organs, including the prostate?	☐	☐
F. Diabetes, thyroid or other glandular disorders?	☐	☐
G. Immune system disorder?	☐	☐
H. Arthritis, back trouble, gout, or other disorders of the muscles, bones or joints?	☐	☐
I. Any disorder of the eyes, ears or skin?	☐	☐
J. Cancer, tumor or lymph node enlargement?	☐	☐
K. Any physical deformity or defect?	☐	☐
L. Any injury, disease, recurrent infection, condition or disorder not indicated above?	☐	☐
4. **Is any person proposed for coverage:**		
A. Presently taking, or within the past year taken any medication, including medication for blood pressure, cholesterol or for any other reason?	☐	☐
B. Contemplating an operation, surgical procedure or biopsy?	☐	☐
C. Contemplating medical or rehabilitative consultation or treatment?	☐	☐
5. **Has any person proposed for coverage gained or lost weight in the past year?** (If "Yes", give pounds gained or lost and reason.)	☐	☐
6. **Has any parent, brother or sister of persons proposed for coverage ever had cancer, stroke, heart disease, diabetes, mental or congenital disorder?** (If deceased, give age at death and cause.)	☐	☐
7. **During the past five years, has any person proposed for coverage had or been advised to have:**		
A. An examination or physical checkup? (Give details in 7C.)	☐	☐
B. X-ray, electrocardiogram, blood studies, or any other laboratory tests or studies? (Give details in 7C.)	☐	☐

C. DETAILS Name	Test Done	Date	Reason For Test	Results	Name/Address/Phone # of Doctors/Hospitals

SUPPLEMENT 1 - ALCOHOL SUPPLEMENT

1. Name of Proposed Insured

2. Degree and frequency of use at present or within one year:
   a. If alcohol **is used daily**, indicate number of drinks per day.
   ☐ None ☐ 1-3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

   b. If alcohol is **not used daily**, indicate degree and frequency.
   ☐ Mild intoxication more than six times per year (not more than six drinks on any one occasion).
   ☐ Usage less than described in "mild intoxication" above. Describe _____
   ☐ Usage more than described in "mild intoxication" above. Describe _____

3. Did you ever drink more than you do at present? ☐ Yes ☐ No
   If "Yes", give dates and complete #4 below. From _____ to _____

4. Degree and frequency of past use:
   a. If alcohol **was used daily**, indicate number of drinks per day.
   ☐ None ☐ 1-3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

   b. If alcohol was **not used daily**, indicate degree and frequency.
   ☐ Mild intoxication more than six times per year (not more than six drinks on any one occasion).
   ☐ Usage less than described in "mild intoxication" above. Describe: _____
   ☐ Usage more than described in "mild intoxication" above. Describe: _____

5a. Have you ever stopped drinking? ☐ Yes ☐ No	5b. When?	5c. Why?
6a. Have you ever stopped and relapsed? ☐ Yes ☐ No	6b. When?	6c. Why?

7. Have you ever consulted a doctor or received treatment or counseling because of your alcohol use? ☐ Yes ☐ No
   If "Yes", name and address of doctor, hospital or treatment center and dates:

8. Are you now or have you ever been a member of Alcoholics Anonymous or any similar organization? ☐ Yes ☐ No
   If "Yes", complete questions below:

a. Presently active? ☐ Yes ☐ No	b. Date joined:	c. How long active?
d. Have any "slips" occurred? ☐ Yes ☐ No	e. If "Yes", when?	

Additional details

SUPPLEMENT 2 - DRUG SUPPLEMENT

1. Name of Proposed Insured

2. Check any drugs used within the past 10 years: ☐ Narcotics ☐ Stimulants ☐ Sedatives ☐ Hallucinogenics

3. Details:

TYPE OF DRUG	HOW OFTEN USED	DOSAGE OR AMOUNT USED	DATES USED	
			FROM	TO

4. Name, address and phone number of physician, therapist, counselor or facility by whom treatment or counseling was provided.

Additional comments:

SUPPLEMENT 3 - AVIATION SUPPLEMENT

1. Name of Proposed Insured

2. Type of license now held	3. Date of issue
4. Total solo hours	5. Date of last flight

6. Certificate(s) held:
☐ IFR ☐ ATR ☐ Other (Describe)

7. Describe nature and purpose of flying	8. Type of plane flown

9. Ever had an aviation accident or violation? ☐ Yes ☐ No (If "Yes", give details.)

10. Ever fly for pay? ☐ Yes ☐ No (If "Yes", give details.)

11. If standard, unrestricted coverage cannot be offered, issue Policy with: ☐ Extra Premium ☐ Aviation Exclusion Rider

12. Type of flying	HOURS PAST 12 MONTHS	HOURS 1-2 YEARS AGO	HOURS CONTEMPLATED NEXT 12 MONTHS
Pilot-civilian			
Student			
Other (Describe)			

13. Additional details

SUPPLEMENT 4 - SPORTS/RODEO/AVOCATIONS SUPPLEMENT

1. Name of Proposed Insured	2. Type of activity/sport/event
3. How long engaged in this activity?	4. How often do you participate?
5. Date of last participation	6. Where does activity take place?
7. If racing, make and type of auto or other vehicle	8. If racing, top speed attained
9a. Do you have any certification or rating? ☐ Yes ☐ No	9b. If "Yes", describe
10a. Do you belong to any professional associations or clubs? ☐ Yes ☐ No	10b. If "Yes", which ones?
11a. Do you participate solely for pleasure? ☐ Yes ☐ No, for profit	11b. If "Profit", explain

12. Activity log

PAST 12 MONTHS	1-2 YEARS AGO	CONTEMPLATED NEXT 12 MONTHS

13. Additional details (Include depth of dives, location, etc.)

REPRESENTATIONS, AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT

By signing this Application, I represent that the statements and answers in all parts of this Application and Supplements thereto are true and complete to the best of my knowledge and belief and it is agreed that:

1. The statements and answers given by the Proposed Insured and the Owner shall be the basis of any insurance issued.
2. Except as provided in the Temporary Life Insurance Agreement attached hereto, no insurance shall take effect unless and until the following conditions are met:
   a. The Policy as applied for has been approved by the Company in its Home Office or if the Policy is issued other than as applied for, the Policy has been physically received and accepted by the Owner;
   b. The first premium has been paid; and
   c. No change in the health or insurability of any persons proposed for coverage has occurred to the best of any Owner's or Proposed Insured's knowledge, between the date of the Application and the date the conditions in 2(a) and 2(b) above are both satisfied.
3. No producer or medical examiner is authorized to pass on acceptability for insurance or to make, modify or discharge any contract of insurance or waive any of the Company's rights or requirements.
4. The right to change any Beneficiary is reserved to the Owner, unless otherwise requested.
5. In the case of any apparent errors or omissions found by the Company in this Application or Supplements thereto, the Company is hereby authorized to amend same by recording the change in the space provided for Home Office Endorsements.
6. If this Application is for other than new business, I further agree that:
   a. This Application shall be considered an amendment and supplement to the original Application and shall form a part of the Policy;
   b. The action requested shall not be effective until it has been approved at the Home Office and any required additional premium has been paid;
   c. My acceptance of any endorsement or rider issued hereon will constitute a ratification of such changes or omissions except that any change in amount, classification, or type of benefits shall be subject to written ratification by me;
   d. The time limit on certain defenses or the contestable period, whichever is applicable, shall, with respect to any action taken by the Company on the basis of statements contained herein, be measured from the effective date of such action;
   e. If this Application is for reinstatement, the Policy benefits shall be as provided in the reinstatement provision; and
   f. If this Application is for conversion of a policy or rider, in whole or in part, to a new plan, I understand the existing policy or rider will be canceled or reissued for the reduced amount on the date the new Policy takes effect.
7. I understand that the accumulated value of the Policy may go up or down depending on the Policy's investment experience and that there is no guaranteed minimum accumulated value. I also understand that the amount of the death benefit or the duration of the death benefit may vary under the conditions described in the death benefit provision of the contract.

I have been asked all questions on the Application and the answers are those given by me.

CERTIFICATION

Under penalties of perjury, I certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. person (including a U.S. resident alien).**

Certification instructions. You must cross out Item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, Item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT

THIS IS A HIPAA COMPLIANT AUTHORIZATION

Farm Bureau Life Insurance Company ("the Company") or its reinsurers may obtain information about me or my minor children from: any physician, medical professional, hospital, medical care facility, government agency, employer, insurance company or institution, consumer reporting agency, or Medical Information Bureau, Inc. (MIB, Inc.). The purpose is to determine eligibility for insurance or benefits. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and may obtain an investigative consumer report.

To facilitate rapid submission of such information, all sources, except MIB, Inc., are authorized to give such information or records to any entity designated by the Company or its reinsurers to collect and transmit such information.

This Authorization includes information about mental health care (other than psychotherapy notes), developmental disability care, and drug and alcohol abuse treatment. I understand that: (1) I can revoke this authorization at any time by written notice to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to process applications or evaluate claims and may be a basis for denying this application or a claim for benefits.

I further understand and acknowledge that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

The Company may disclose information to: its reinsurers, those who perform services for the Company or its reinsurers, those companies to which I have applied or may apply for life or health insurance or benefits, and the Company's affiliates for claims handling, servicing, underwriting, insurance marketing, and other purposes. Disclosure may also be made when required or permitted by law. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

I understand that I have the right to see personal information collected about me, and have the right to correct any information which may be wrong. I understand that I may obtain a description of this Company's information practices by requesting one from my producer or the Company at the address provided with my Policy.

This Authorization is valid for 24 months from the date below. A copy of this Authorization shall be as valid as the original.

I have received a copy of this Authorization and the Important Notices, and have read the representations on the previous page.

The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Dated at (city and state) _____ On (date) _____

_____ _____

Signature of Proposed Insured 1 Signature of Owner (If not Proposed Insured)

_____ _____

Signature of Proposed Insured 2 Signature of Owner (If not Proposed Insured)

_____ _____

Signature of Agent Signature of Parent or Guardian if a child is under age 15

Farm Bureau Life Insurance Company
5400 University Avenue
West Des Moines, Iowa
50266-5997

FARM BUREAU FINANCIAL SERVICES

FOR HOME OFFICE USE

CONTROL/POLICY NUMBER

CHECK WRITING DAY

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER PAYMENT PLAN

The undersigned request and authorize you to automatically make a withdrawal each month from the financial institution indicated to pay premiums and loans for insurance policies from the account identified on the attached check, by electronic or other method. Please do this until you have had reasonable opportunity to act upon a written request to terminate this service.

Account Type: ☐ Checking ☐ Savings **Preferred Withdrawal Date:** _____

This request shall apply to the following policies or new applications:

POLICY # OR APPLICATION DATE	NAME OF INSURED	POLICY # OR APPLICATION DATE	NAME OF INSURED

If this is a Universal Life/Flexible Variable Life/Annuity Policy, indicate the start date and amount of premium desired.

Start Date: _____ Premium: _____

Other policies drafting on this bank account: _____

_____ _____
Signature of Bank Account Owner Date

_____ _____
Signature of Bank Account Owner Date

_____ _____
Agent Signature Agent Number

Do you want us to change your address as shown on the voided check? ☐ **Yes** ☐ **No**

PLEASE ATTACH VOIDED CHECK HERE

(Do not use deposit slips.)

1. The Company shall not be required to give notice of premium becoming due. The Company shall incur no liability by reason of dishonor of any such withdrawal.
2. This payment plan may be discontinued (a) by the Company if any draft is not paid upon presentation, or (b) by the Bank Account Owner or the Company upon thirty days written notice. If a Policy is discontinued for any reason, including death, any premiums then past due, and all subsequent premiums, shall be payable as provided in the Policy.
3. This payment plan shall not be construed as a modification of any of the provisions of the Policy, except that so long as the payment plan is in effect, premiums may be paid monthly at the applicable premium rate.
4. On policies previously issued where dividends have been applied to reduce premiums, this shall act as a request to have the dividend applied to purchase Paid-Up Additions, Option 4 (or Leave to accumulate, Option 3, on any term policy), unless one of the following options is checked.
   - ☐ Option 1, Pay in cash
   - ☐ Option 3, Leave to accumulate

AGENT'S CERTIFICATE

1. Teleunderwriting: Did you fax the request to LabOne? ☐ Yes ☐ No
   Did you fax the Application and the fax cover sheet to FBL? ☐ Yes ☐ No
   Did you provide the brochure to the Proposed Insured? ☐ Yes ☐ No
2. Have you ordered: Examination ☐ Yes ☐ No Blood Profile ☐ Yes ☐ No
   Indicate the "key" letter used for the medical requirements _____
3. Did you advise the Proposed Insured(s) that they may be contacted by the Company or its authorized representative for the completion of a telephone interview? ☐ Yes ☐ No
4. Did you provide the Important Notices form to the Proposed Insured? ☐ Yes ☐ No
5. Did you see all persons proposed for insurance? ☐ Yes ☐ No
   If "No" explain: _____
6. Did you complete Sections F and G as they apply to ALL children to be included in any term riders? ☐ Yes ☐ No
7. How long have you known the Applicant and Proposed Insured(s)? _____ Related? ☐ Yes ☐ No
8. Were you approached for this insurance? ☐ Yes ☐ No
   If "yes" explain: _____
9. If the beneficiary is not a relative or business associate, explain fully the insurable interest.
   _____
   _____
10. Spouse's name and amount of life insurance in force.
    _____
11. Purpose of Insurance:
    ☐ Human Life Value (Income Needs) ☐ Cash Needs ☐ Debt Protection
    ☐ Mortgage Acceleration ☐ Social Security Offset ☐ Maximize Pension
    ☐ Business Insurance – give details ☐ Estate Needs ☐ Trust Funding
    Other (explain): _____
    _____
    _____
    Send all supporting documents to expedite the application process.

QUESTIONS REGARDING REPLACEMENT

12. Are you aware of any existing life insurance or annuities not otherwise disclosed in this Application? ☐ Yes ☐ No
13. Are you aware of any proposed replacement not otherwise disclosed in this Application? ☐ Yes ☐ No
    If questions 12 and/or 13 are "Yes", explain (including any proposed replacement):
    _____
    _____
14. For any replacement, indicate the type of coverage proposed to be replaced:
    ☐ Term Life ☐ Whole Life ☐ Variable Life ☐ Fixed Annuity ☐ Variable Annuity ☐ Universal Life
    ☐ Other – be specific _____
    a. Advertising Materials:
       - I certify that I used only insurer-approved sales materials with this Application and that an original or copy of all sales materials was left with the owner.
       - I certify that a printed copy of electronically presented sales materials was/will be provided to the Owner no later than the date the Policy is delivered.
       - For replacements subject to the Model Life Insurance and Annuity Replacement Regulation*, copies of any individualized sales material (including illustrations) must be submitted with the Application.

         *This includes Arizona, Colorado, Iowa, Montana, and New Mexico.

    b. I certify that this Application is in accordance with the Company's written statement of the Company's position with respect to the acceptability of replacements. (Refer to your electronic version of the reference manual for additional information.)
       If "not", please explain: _____
       _____
15. Is there a simultaneous application submitted to any other company? ☐ Yes ☐ No
    Company _____ Amount $_____
    Will all be accepted, if issued? ☐ Yes ☐ No

The answers to each question of this Application were recorded in my presence exactly as given. I have rechecked all answers and calculations for correctness.

Signature of Agent _____ Date _____

TEMPORARY LIFE INSURANCE AGREEMENT

This Agreement provides a limited amount of life insurance coverage, for a limited period of time, subject to the terms of this Agreement. **No insurance is provided unless all the conditions and limitations of this Agreement are met.**

CONDITIONS AND LIMITATIONS

Amount of coverage - $150,000 maximum for all applications or agreements.

If the Company accepts money as payment of premium with an application for life insurance, and a Proposed Insured in the Application dies while this temporary life insurance agreement is in effect, the Company will pay to the Designated Beneficiary in the Application the lesser of (a) the amount of all death benefits applied for, or (b) in case of replacement of or conversion from an existing Company policy, the amount of all death benefits applied for less the death benefit payable on the existing policy(ies), or (c) $150,000. For purposes of this Agreement, "Designated Beneficiary" shall mean the Beneficiary as determined in accordance with the provisions of the Policy for which application is being made. The total benefit limit is the total of the Company's liability without regard to the amount of insurance applied for under this Application or any other pending applications with the Company and, in the event any other temporary insurance agreements are in existence at the time of the Proposed Insured's death, $150,000 is the aggregate liability under all temporary life insurance agreements.

Except as provided in this Agreement, no insurance shall take effect unless and until the following conditions are met: (a) the Policy as applied for has been approved by the Company in its Administrative Office or if the Policy is issued other than as applied for, the Policy has been physically received and accepted by the Owner; (b) the first premium has been paid; and (c) no change in health and insurability of any Proposed Insured has occurred to the best of any Owner's or Proposed Insured's knowledge between the date of the Application and the date the conditions in (a) and (b) of this paragraph are both satisfied.

DATE COVERAGE BEGINS

Temporary life insurance under the Agreement begins on the date of this Agreement subject to the following conditions: (a) the Application has been completed on or before the date of this Agreement, and (b) the health questions below are both answered "No" and (c) the Company accepts money as payment of premium.

DATE COVERAGE TERMINATES - 60 DAY MAXIMUM

Temporary life insurance under this Agreement terminates automatically at the earliest of:

1. 60 days from the date of this Agreement, or
2. the date insurance takes effect under the Policy applied for, or
3. the date a policy, other than as applied for, is offered to and accepted by the Owner, or
4. the date the Company mails notice of termination of coverage and refunds the payment to the Owner at the address designated in Section B of the Application. The Company may terminate this coverage at any time.

LIMITATIONS

1. This Agreement does not provide any benefits under any Waiver of Premium provision of the Policy.
2. Fraud or material misrepresentation in the Application or in the answers to the health questions of this Agreement invalidates this Agreement and the Application, and the Company's only liability is for refund of any payment made.
3. No one is authorized to accept money on Proposed Insureds less than 7 days of age or over age 80 (last birthday) on the date of the Application, nor will any coverage take effect.
4. There is no insurance coverage under this Agreement if a Proposed Insured dies by suicide. The Company's liability is limited to a refund of any payment made.
5. **There is no coverage under this Agreement if no money is submitted with this Application or if the check submitted for payment is not honored by the financial institution at first presentation.**
6. No one is authorized to waive or modify any of the provisions of this Agreement.

HEALTH QUESTIONS - HAS ANY PROPOSED INSURED:

1. Within the past 90 days, other than for pregnancy or childbirth, been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? For purposes of this question, "admitted" is considered to be 12 continuous hours in the facility. ☐ **Yes** ☐ **No**
2. Within the past 2 years, been treated for chest pain, heart trouble, stroke/CVA, or cancer, or had such treatment recommended by a physician or other practitioner? ☐ **Yes** ☐ **No**

If either Question #1 or Question #2 above is answered "Yes" or left blank, no coverage will take effect under the Temporary Life Insurance Agreement.

I have read and received a copy of this Agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to all of its terms.

A sum of $_____ has been paid with the Application for life insurance. Additional premium may be required upon Policy delivery.

Dated at (city and state) _____ On (date) _____

_____ _____

Signature of Proposed Insured 1 Signature of Proposed Insured 2

_____ _____

Signature of Agent Signature of Owner (if not Proposed Insured)

TEMPORARY LIFE INSURANCE AGREEMENT

This Agreement provides a limited amount of life insurance coverage, for a limited period of time, subject to the terms of this Agreement. **No insurance is provided unless all the conditions and limitations of this Agreement are met.**

CONDITIONS AND LIMITATIONS

Amount of coverage - $150,000 maximum for all applications or agreements.

If the Company accepts money as payment of premium with an application for life insurance, and a Proposed Insured in the Application dies while this temporary life insurance agreement is in effect, the Company will pay to the Designated Beneficiary in the Application the lesser of (a) the amount of all death benefits applied for, or (b) in case of replacement of or conversion from an existing Company policy, the amount of all death benefits applied for less the death benefit payable on the existing policy(ies), or (c) $150,000. For purposes of this Agreement, "Designated Beneficiary" shall mean the Beneficiary as determined in accordance with the provisions of the Policy for which application is being made. The total benefit limit is the total of the Company's liability without regard to the amount of insurance applied for under this Application or any other pending applications with the Company and, in the event any other temporary insurance agreements are in existence at the time of the Proposed Insured's death, $150,000 is the aggregate liability under all temporary life insurance agreements.

Except as provided in this Agreement, no insurance shall take effect unless and until the following conditions are met: (a) the Policy as applied for has been approved by the Company in its Administrative Office or if the Policy is issued other than as applied for, the Policy has been physically received and accepted by the Owner; (b) the first premium has been paid; and (c) no change in health and insurability of any Proposed Insured has occurred to the best of any Owner's or Proposed Insured's knowledge between the date of the Application and the date the conditions in (a) and (b) of this paragraph are both satisfied.

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DATE COVERAGE TERMINATES - 60 DAY MAXIMUM

Temporary life insurance under this Agreement terminates automatically at the earliest of:

1. 60 days from the date of this Agreement, or
2. the date insurance takes effect under the Policy applied for, or
3. the date a policy, other than as applied for, is offered to and accepted by the Owner, or
4. the date the Company mails notice of termination of coverage and refunds the payment to the Owner at the address designated in Section B of the Application. The Company may terminate this coverage at any time.

LIMITATIONS

1. This Agreement does not provide any benefits under any Waiver of Premium provision of the Policy.
2. Fraud or material misrepresentation in the Application or in the answers to the health questions of this Agreement invalidates this Agreement and the Application, and the Company's only liability is for refund of any payment made.
3. No one is authorized to accept money on Proposed Insureds less than 7 days of age or over age 80 (last birthday) on the date of the Application, nor will any coverage take effect.
4. There is no insurance coverage under this Agreement if a Proposed Insured dies by suicide. The Company's liability is limited to a refund of any payment made.
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HEALTH QUESTIONS - HAS ANY PROPOSED INSURED:

1. Within the past 90 days, other than for pregnancy or childbirth, been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? For purposes of this question, "admitted" is considered to be 12 continuous hours in the facility. ☐ **Yes** ☐ **No**
2. Within the past 2 years, been treated for chest pain, heart trouble, stroke/CVA, or cancer, or had such treatment recommended by a physician or other practitioner? ☐ **Yes** ☐ **No**

If either Question #1 or Question #2 above is answered "Yes" or left blank, no coverage will take effect under the Temporary Life Insurance Agreement.

I have read and received a copy of this Agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to all of its terms.

A sum of $_____ has been paid with the Application for life insurance. Additional premium may be required upon Policy delivery.

Dated at (city and state) _____ On (date) _____

_____ _____

Signature of Proposed Insured 1 Signature of Proposed Insured 2

_____ _____

Signature of Agent Signature of Owner (if not Proposed Insured)

IMPORTANT – MEDICAL INFORMATION BUREAU, INC.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Medical Information Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Medical Information Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Medical Information Bureau's file, you may contact the Medical Information Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Medical Information Bureau's information office is:

PO Box 105, Essex Station, Boston, Massachusetts 02112
Telephone number (617) 426-3660

The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

IMPORTANT – FAIR CREDIT REPORTING ACT

Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to the Company or its reinsurers, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry may include questions regarding your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation requested. You also have the right to receive, upon request, a summary of your rights under the Fair Credit Reporting Act.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT – (COPY FOR INSURED'S FILES)

Farm Bureau Life Insurance Company ("the Company") or its reinsurers may obtain information about me or my minor children from: any physician, medical professional, hospital, medical care facility, government agency, employer, insurance company or institution, consumer reporting agency, or Medical Information Bureau, Inc. (MIB, Inc.). The purpose is to determine eligibility for insurance or benefits. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and may obtain an investigative consumer report.

To facilitate rapid submission of such information, all sources, except MIB, Inc., are authorized to give such information or records to any entity designated by the Company or its reinsurers to collect and transmit such information.

This Authorization includes information about mental health care (other than psychotherapy notes), developmental disability care, and drug and alcohol abuse treatment. I understand that: (1) I can revoke this Authorization at any time by written notice to the Company; (2) revocation of this Authorization will not affect any prior action taken by the Company in reliance upon this Authorization; and (3) failure to sign, or revocation of this Authorization may impair the Company's ability to process applications or evaluate claims and may be a basis for denying this application or a claim for benefits.

I further understand and acknowledge that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

The Company may disclose information to: its reinsurers, those who perform services for the Company or its reinsurers, those companies to which I have applied or may apply for life or health insurance or benefits, and the Company's affiliates for claims handling, servicing, underwriting, insurance marketing, and other purposes. Disclosure may also be made when required or permitted by law. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

I understand that I have the right to see personal information collected about me, and have the right to correct any information which may be wrong. I understand that I may obtain a description of this Company's information practices by requesting one from my agent or the Company at the address provided with my Policy.

This Authorization is valid for 24 months from the date signed. A copy of this Authorization shall be as valid as the original.

Farm Bureau Life Insurance Company
5400 University Avenue
West Des Moines, IA
50266-5997

FARM BUREAU FINANCIAL SERVICES

Notice to Applicants Regarding Replacement of Life Insurance or Annuities

IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____YES _____ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____YES _____NO**

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	ANNUITANT OR INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.
The existing policy or contract is being replaced because

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____	_____
Applicant's Name (printed)	Producer's Name (printed)
_____	_____
Applicant's Signature	Producer's Signature
_____	_____
Date	Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

Notice continued on next page.

IF THE NEW POLICY IS A REPLACEMENT, THE FOLLOWING NOTICE APPLIES:
NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

The owner may cancel this policy by delivering or mailing a written notice, sending a telegram or fax to the agent through whom it was purchased or the Farm Bureau Life Insurance Company, 5400 University Avenue, West Des Moines, Iowa 50266-5997 and by returning the policy or contract before midnight of the thirtieth day after the date you receive the policy. Notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed and postage prepaid. The amount to be refunded is described on the first page of your policy or contract.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

Farm Bureau Life Insurance Company
5400 University Avenue
West Des Moines, IA
50266-5997

FARM BUREAU FINANCIAL SERVICES

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IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____YES _____ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____YES _____NO**

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	ANNUITANT OR INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.
The existing policy or contract is being replaced because

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____	_____
Applicant's Name (printed)	Producer's Name (printed)
_____	_____
Applicant's Signature	Producer's Signature
_____	_____
Date	Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

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A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?