FARMERS LIFE INSURANCE COMPANY

Surrender Charge Waiver Request
Terminal Illness or Qualified Nursing Care Facility Confinement

1. Important Information

Use this form and the attached HIPAA authorization to request a waiver of surrender charge and market value adjustment due to the contract owner's terminal illness or confinement in a qualified nursing care facility. If the contract owner is not a natural person (e.g., trust, corporation), the contract annuitant is deemed to be the owner for purposes of eligible terminal illness or confinement.

Please note the following:

- You must serve your waiting period for eligibility for this waiver of surrender charge and market value adjustment feature. See the rider data section of your contract for your waiting period.

For Waiver of Surrender Charge or MVA Due to Confinement in a Qualified Nursing Care Facility:

- Your confinement in the qualified nursing care facility must begin after the contract effective date.
- Your confinement in the qualified nursing care facility must meet the minimum number of consecutive days. For example, if your contract requires a minimum confinement of 90 consecutive days in the qualified nursing care facility, a waiver request may not be submitted until that period of time has elapsed. See the rider data section of your contract for your required minimum number of consecutive days of confinement.
- Qualified nursing care facility means a hospice care facility, hospital, intermediate care facility or skilled nursing care facility that is licensed and operates according to the laws of the state in which it is located. It does not include:
  - Drug or alcohol treatment facilities.
  - Homes for the aged or mentally ill.
  - Community living centers.
  - Facilities that primarily provide domiciliary, residency, or retirement care.
  - Facilities owned or operated by you or any member of your immediate family.

For Waiver of Surrender Charge or MVA Due to Terminal Illness:

- You have been diagnosed by a qualified physician with a medical condition expected to result in death within one year.

- Qualified physician means a person who is licensed as an M.D. or D.O. It does not include you or any member of your immediate family.
- Farmers Life Insurance Company may require updated information on a regular basis.
- Ordinary income taxes and IRS early withdrawal penalties (if under age 59½) may apply to amounts surrendered. Please consult your financial or tax professional.

2. Contract Information

Contract number

Contract owner full legal name | Birth date (mm/dd/yyyy)

Street address | City | State | ZIP

Phone | Email

Contract annuitant full legal name *(if the contract owner is not a natural person)* | Birth date (mm/dd/yyyy)

Street address | City | State | ZIP

Phone | Email

Financial professional full legal name *(if applicable)*

Phone | Email

3. Qualified Nursing Care Facility Information

Complete this section only if submitting a request due to confinement in a qualified nursing care facility:

To be completed and signed by attending qualified physician.

Qualified attending physician full legal name

Phone | Email

Qualified nursing care facility full legal name | Phone

Street address | City | State | ZIP

Licensed as (type of facility): _____

Licensed by: ☐ State ☐ County ☐ City ☐ Other _____

Effective dates of license (mm/dd/yyyy): _____

Please enclose a copy of your most recently issued license.

Admission to facility (mm/dd/yyyy) | Discharge from facility (mm/dd/yyyy) ☐ Check if still confined

Past admission to facility (mm/dd/yyyy) | Past discharge from facility (mm/dd/yyyy)

Past admission to facility (mm/dd/yyyy) | Past discharge from facility (mm/dd/yyyy)

By signing below, I certify that this information is complete and accurate to the best of my knowledge and belief.

Qualified attending physician signature | Signed at (city/state) | Date signed (mm/dd/yyyy)

4. Terminal Illness Information

Complete this section only if submitting a request due to terminal illness:

To be completed and signed by attending qualified physician.

_____
Qualified attending physician full legal name

_____ _____
Phone Email

The claimant, _____, has been diagnosed, as of _____ (date of diagnosis) with a medical condition that is expected to result in death within one year. In support of this diagnosis, I am attaching proof of diagnosis.

By signing below, I certify that this information is complete and accurate to the best of my knowledge and belief.

_____ _____ _____
Qualified attending physician signature Signed at (city/state) Date signed (mm/dd/yyyy)

5. Signatures

I understand that Farmers Life Insurance Company will honor this waiver of surrender charge request according to the terms of the contract. This form is provided at my request and is not to be considered as an admission of the validity of any claim, nor a waiver of any of Famers Life Insurance Company's rights or defenses. Any person who knowingly and with intent to defraud any insurance company or other persons files a 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 subject to criminal prosecution and/or civil penalties. Under the penalties of perjury, I represent that the information contained in this form is complete and accurate to the best of my knowledge and belief. **Please refer to the enclosed state fraud warnings for state-specific wording regarding the above fraud statement.**

_____ _____
Contract owner signature Date signed (mm/dd/yyyy)

Signing as (please check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____

_____ _____
Contract annuitant signature *(if the contract owner is not a natural person)* Date signed (mm/dd/yyyy)

Signing as (please check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____

6. State Fraud Warnings

The following states have specific fraud laws regarding insurance claims. States not listed may also have laws including penalties for misrepresentation, intentional omissions and deceptive acts.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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.

Delaware: Any person who knowingly and with intent to insure defrauds or deceives any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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 any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement containing any false, incomplete or misleading information is guilty of a felony.

Illinois: Any person who knowingly present false information in an application for insurance or a viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

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.

Louisiana: 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.

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 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: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution or punishment for insurance fraud, as provided in RSA 638.20.

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.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he 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.

Oregon: Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent act, which is a crime.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: 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.

Tennessee: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: 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.

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.

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.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.

FARMERS LIFE INSURANCE COMPANY

HIPAA Compliant Authorization

1. Important Information

This authorization is intended to comply with HIPAA. HIPAA stands for Health Insurance Portability and Accountability Act of 1996, as amended. It provides your physicians and care providers with authorization to release to us medical information that pertains to your request.

Complete this form and return the completed and signed form to Farmers Life Insurance Company. Keep a copy for yourself.

2. Owner and Annuitant Information

Contract number

Contract owner full legal name | Birth date

Street address | City | State | ZIP

Phone | Email

Contract annuitant full legal name *(if the contract owner is not a natural person)* | Birth date(s)

Street address | City | State | ZIP

Phone | Email

Financial professional full legal name *(if applicable)*

Phone | Email

3. Authorization

I authorize the following uses and disclosures of health information about me:

- The health information that I am authorizing to be used or disclosed consist of my medical records, medical history and any other information that relates to the diagnosis of any physical or mental condition or the treatment or prognosis of any physical or mental condition resulting in a qualifying event or instance applicable to my request for waiver of surrender charges.
- The following persons or entities are authorized to disclose health information about me: (a) a physician, doctor or medical practitioner; (b) a hospice care facility, hospital, intermediate care facility or skilled nursing care facility; any insurance or reinsurance company, including Farmers Life Insurance Company; (c) any consumer reporting agency such as the MIB, Inc; and (d) any other organization, institution or person having health information about me.
- Health information about me may be disclosed to Farmers Life Insurance Company and its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as the MIB, Inc.
- Health information about me may be used or disclosed to evaluate or process any benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization.

- Farmers Life Insurance Company is authorized to disclose health information about me to the individual designated below. You may want to consider listing your spouse, partner, children and/or any other family member or friend with whom you may want or allow Farmers Life Insurance Company to discuss your claim.

Full legal name _____ Phone _____

Full legal name _____ Phone _____

Full legal name _____ Phone _____

Full legal name _____ Phone _____

I understand that:

- If I do not sign this authorization, Farmers Life Insurance Company may decline my benefit or waiver request.
- Although an authorization may generally be revoked by sending a written request to Farmers Life Insurance Company, there is no right to revoke this authorization if my claim for benefits may be contested by Farmers Life Insurance Company or if Farmers Life Insurance Company has already relied and acted upon this authorization.
- A copy of this authorization is as valid as the original, whether hard copy or electronic.
- This authorization expires when coverage under the annuity terminates. Exception: For California residents, this authorization is valid for the duration of the claim for benefits.

4. Signatures

Any person who knowingly and with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, is guilty of insurance fraud and may be subject to criminal or civil penalties. Under the penalties of perjury, I represent that the information contained in this form is complete and accurate to the best of my knowledge and belief. **Please refer to the enclosed state fraud warnings for state-specific wording regarding the above fraud statement.**

If this authorization is signed by a trustee, attorney-in-fact or guardian, a copy of the trust certification or power of attorney or guardianship document must be included.

Contract owner signature _____ Date signed (mm/dd/yyyy) _____

Signing as (please check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____

Contract annuitant signature *(if the contract owner is not a natural person)* _____ Date signed (mm/dd/yyyy) _____

Signing as (please check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____