



APPLICATION FOR LIFE INSURANCE

New York Only

INCLUDING THE FOLLOWING FORMS:

- **Appendix 11** Insurance Department of the State of New York Definition of Replacement - Form Reg. 60 Ex. 11 (Required with all applications)
- **Application for Electronic Funds Transfer (EFT)** Form of Premium Payment - Form 17-091-00 EFT

INSTRUCTIONS TO AGENTS AND APPLICANTS

1. **Conditional Receipt** - The Conditional Receipt must be given to the Applicant/Owner if a premium payment is made. No agent has the authority to alter the provisions of the Conditional Receipt.
2. **Special Requirements** - If special requirements need to be considered, be sure to submit a separate cover letter with all details.
3. **Insurance Age** - Insurance age is calculated based on the Proposed Insured's **age nearest birthday**.
4. **Premium Deposit Required** - A premium deposit at least equal to the policy modal premium must be submitted with the application, except when:
 - it appears that the policy may be rated
 - the policy face amount exceeds \$500,000

FARMERS AND TRADERS LIFE INSURANCE COMPANY
960 James Street, P.O. Box 1056, Syracuse, NY 13201-1056



**Farmers
& Traders
Life Insurance Co.**

A NEW YORK MUTUAL COMPANY

APPLICATION FOR LIFE INSURANCE
Farmers and Traders Life Insurance Company
960 James Street, P.O. Box 1056
Syracuse, NY 13201-1056

Persons Proposed for Insurance (Section A)

(Insurance Age is Age Nearest Birthday. Use A(5) if additional space needed.)

1. Primary Insured		Last Name		First Name		MI	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth Mo./Day/Yr.
Social Security No.								
Residence Address	Street	City	ST	Zip	County	Driver's License State and Number		
Home Telephone ()		Primary Insured's Place of Birth						
If the primary insured is a minor, name of the guardian				What is the relationship?				
Business Address	Street	City	ST	Zip	Business Telephone ()			

2. Send Premium Notices to: Insured's Home Insured's Business Owner

3. Primary Owner (only if not Primary Insured)		Last Name		First Name		MI	Relationship to Primary Insured
Soc.Sec. or Tax ID No.							
Owner Mailing Address	Street	City	ST	Zip	County		
Telephone ()		Primary Insured to become Owner <input type="checkbox"/> At Age ____ <input type="checkbox"/> At Owner's Death					

4. Beneficiary	Name	Relationship to Primary Insured
Primary Beneficiary		
Contingent Beneficiary		

Unless otherwise noted in this or a later beneficiary designation, the right to change the beneficiary is reserved and the proceeds are to be divided equally among all persons who are named as Primary Beneficiary and who survive the insured. If none survive, then equally among all persons who are named as Contingent Beneficiary and who survive the insured.
The beneficiary of any insurance rider on the spouse or children shall be the insured unless otherwise noted.

5. Remarks and Special Requests:

Complete 6- 7 only if Spouse, Payor Death and Disability, or Child Rider applied for

6. Spouse Insured, Or Payor, if Payor Dth. and Dis. Benefit Applied for	Last Name (include Maiden Name if different)	First Name	MI	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth	Place of Birth
Social Security No.						

7. Dependent Children - Complete only if coverage is proposed for dependent children under age 17 1/2.	Last Name	First Name	MI	Sex	Date of Birth	Height in inches	Wt. In Lbs.
Social Security No.				<input type="checkbox"/> F <input type="checkbox"/> M			
Social Security No.				<input type="checkbox"/> F <input type="checkbox"/> M			
Social Security No.				<input type="checkbox"/> F <input type="checkbox"/> M			
Social Security No.				<input type="checkbox"/> F <input type="checkbox"/> M			

Are all children listed above the natural, step, or legally adopted children of the proposed primary insured or spouse? Yes No - If no, explain in A(5)

Do the children listed above reside permanently with the proposed primary insured? Yes No - If no, explain in A(5)

Coverage Information (Section B)

1. Primary Insured Coverage - CHOOSE WHOLE LIFE, TERM, OR UNIVERSAL LIFE			
Automatic Premium Loan? - RESPONSE REQUIRED - (Not available on Term or Universal Life)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>WHOLE LIFE PLAN</p> <p>Plan Name: _____</p> <p><input type="checkbox"/> Face Amount <u>OR</u> <input type="checkbox"/> Premium \$ _____</p> <p>Dividend Option</p> <p><input type="checkbox"/> Cash <input type="checkbox"/> Reduce Premium <input type="checkbox"/> Accum. At Interest <input type="checkbox"/> Paid Up Additions <input type="checkbox"/> EOL Div. Option (EOL Plan Only)</p> <p>WL Benefits</p> <p><input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Payor Death and Disability <input type="checkbox"/> Accel. Death Bene. <input type="checkbox"/> Other _____</p> <p>Primary Insured Term Rider</p> <p><input type="checkbox"/> Plan Name _____ Face Amount \$ _____</p> <p>Paid-up Additions Rider</p> <p><input type="checkbox"/> Level Premium \$ _____ <input type="checkbox"/> Single Premium \$ _____</p>	<p>TERM PLAN (Not Term Rider)</p> <p>Plan Name: _____</p> <p><input type="checkbox"/> Face Amount <u>OR</u> <input type="checkbox"/> Premium \$ _____</p> <p>Term Benefits</p> <p><input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Accelerated Death Benefit <input type="checkbox"/> Other _____</p> <p>Spouse Term Rider</p> <p>Plan Name _____ Face Amount \$ _____</p> <p>Child Term Rider - \$1,000 of coverage/unit (1/2 units available)</p> <p>_____ Units of Child Rider</p>	<p>UNIVERSAL LIFE</p> <p>Face Amount: \$ _____ Planned Premium Initial Pour-in \$ _____ \$ _____</p> <p>UL Benefits</p> <p><input type="checkbox"/> Waiver of Monthly Deduction <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Accelerated Death Benefit <input type="checkbox"/> Other _____</p> <p>UL Death Benefit Option</p> <p><input type="checkbox"/> Option A (Increasing Face) <input type="checkbox"/> Option B (Level Face)</p>	
<p>2. Smoker Status</p> <p>Has any proposed insured:</p> <p>a. Smoked cigarettes within the last 12 months?</p> <p>b. Used tobacco in any form during the past 12 months?</p> <p>c. Used tobacco in any form during the past 36 months?</p> <p>If yes to 2(a), 2(b), or 2(c), provide details in Section C(3) "Details".</p>		<p>Primary Insured</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>Spouse</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>3. Frequency and Method</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (EFT ONLY)</p> <p><input type="checkbox"/> Government Allotment (Complete Government Allotment Forms)</p> <p><input type="checkbox"/> Group Bill (Complete Group Billing Information, Below)</p>			
<p>4. Group Billing Information</p> <p>Name of Group Sponsor (Employer, Association, etc.):</p>		<p>Estimated Group Bill Date:</p>	<p>Group Number if Known:</p>
<p>5. Complete for Tax qualified Life Insurance</p> <p><input type="checkbox"/> HR-10 <input type="checkbox"/> TSA <input type="checkbox"/> Pension Trust <input type="checkbox"/> Profit Sharing <input type="checkbox"/> Other _____</p>			

6. Existing Coverage - Complete for all persons proposed for coverage. List life policies and annuity contracts. If none, write "None". Attach additional sheet(s) as necessary.

Insured	Company	Face Amount	ADB Amount	Issue Year	Insured	Company	Face Amount	ADB Amount	Issue Year
					If the proposed primary insured is a minor, how much life insurance is in force on the: Parent(s) _____ Guardian(s): _____				

7. Will this contract replace any existing insurance or annuity policies? Yes No

If yes, indicate the Company name, plan of life insurance or annuity, and policy number for each plan being replaced. **Attach additional sheet(s) as necessary.**

Personal and Family Information (Section C)

1. Occupation(s):	Primary Insured	Spouse (If Spouse Rider Applied For)	Payor (If Payor Death and Dis. Benefit Applied For)
Present Occupation:			
Duties:			
Employer Name and Address:			
Employed Full-time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Income	Earned		
	Unearned		

2. Treatment, Driving Record, Avocation Information

Provide details of any "Yes" answers, in Section C(3) "Details"	Primary Insured	Spouse Insured or Payor if Payor Death and Disability Benefit Applied For		
	Yes	No	Yes	No
Has any person proposed for insurance:				
a. Ever received treatment, or joined an organization because of alcohol or drug dependence or abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past three years, been convicted of a motor vehicle moving violation, or had driver's license suspended or revoked? If yes, list driver's license number and state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Number	State	Number	State
c. Flown as a pilot or crewmember within the past two years, or plan to do so in the future? If yes, the Aviation Questionnaire is required.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Participated in any hazardous sports within the past two years such as sky, skin or scuba diving, motor racing, hang gliding - or plan to do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Intend to travel or reside outside the U.S. or Canada?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Within the past ten years:				
1. Been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome ("AIDS") or AIDS Related Complex ("ARC")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Been treated by a member of the medical profession for AIDS or ARC?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Has any person proposed for insurance ever had an application for insurance or reinstatement of insurance declined, postponed, rated or modified? If yes, give name, date, company and reason in "Details", Section C(3), below.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Is there anyone proposed for insurance who is not either a U.S. citizen or a permanent resident with a Visa? If "Yes" , explain in "Details", Section C(3).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Details	Give details here for “Yes” responses to Section C(2), Questions a-h, and “Smoker Status” Section B(2) Question b. Attach additional sheet(s) as necessary.

4. Personal Information	Responses required for all applications. Attach additional sheet(s) as necessary.
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<p style="text-align: center;">Primary Insured</p> <p>a. Height in inches _____ Wt. in Lbs. _____</p> <p>b. Change in weight last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Gain _____ Lbs. Loss _____ Lbs.</p> <p>c. Reason: _____</p> <p>d. Name, address, phone of personal physician. If no physician, write “None”: Ph () - _____ _____</p> <p>e. Date and reason last consulted: _____ _____</p> <p>f. What treatment was given or medication prescribed? _____ _____</p> <p>g. Date this physician first consulted: _____</p> <p style="text-align: center;">If less than two years ago, Name, address, phone of previous physician: Ph () - _____ _____</p>	<p style="text-align: center;">Spouse Insured <u>or</u> Payor if Payor Death and Disability Benefit Applied For</p> <p>a. Height in inches _____ Wt. in Lbs. _____</p> <p>b. Change in weight last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Gain _____ Lbs. Loss _____ Lbs.</p> <p>c. Reason: _____</p> <p>d. Name, address, phone of personal physician. If no physician, write “None”: Ph () - _____ _____</p> <p>e. Date and reason last consulted: _____ _____</p> <p>f. What treatment was given or medication prescribed? _____ _____</p> <p>g. Date this physician first consulted: _____</p> <p style="text-align: center;">If less than two years ago, Name, address, phone of previous physician: Ph () - _____ _____</p>
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h. Primary Insured's Family Record		If Living	If Deceased	
	Age	Health Status	Age at Death	Cause of Death
Mother				
Father				
Brother/Sister				
i. Spouse Insured's Family Record				
Mother				
Father				
Brother/Sister				

5. Non-medical Questionnaire	To be answered for or with reference to all family members proposed for insurance. Record details of any "Yes" answers, in Section C(6) "Details to Questions".	Primary Insured		Spouse Or Payor if Payor Death and Disability applied For		Dependent Children	
A. Has any person proposed for insurance either currently or within the past five years:		Yes	No	Yes	No	Yes	No
1. Had an X-ray, Electrocardiogram, or other diagnostic test other than an HIV test?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Had observation or treatment at a clinic, hospital, sanitarium or other medical facility?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Contemplated any surgical procedure or hospitalization or sought any other medical advice?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Had chronic cough, weight loss of 10 or more pounds, chronic fatigue, diarrhea, enlarged lymph glands, or fever for 10 or more days?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Used narcotics or other illegal or controlled substance not prescribed by a physician?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Has any person proposed for insurance ever been treated for or had any known indication of:							
1. Chest pain, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cancer, tumor, cyst, disease of skin or lymph glands?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Asthma, bronchitis, emphysema, shortness of breath or other disease of the lungs or chronic respiratory disorder?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes, thyroid or other endocrine disorders?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Fainting, epilepsy, seizures, paralysis or stroke, depression or any other nervous or mental disorder; abnormality of the brain?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hernia, ulcer or other disorder of the stomach, gall bladder, liver, intestines or rectum?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sugar or albumin in urine, stone or other disorder of kidney, bladder, prostate; disorder of reproductive organs?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Disorder of muscles, bone, joint, back, spine, arthritis or amputation?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Anemia or other disorder of the blood?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Disorder of eyes, ears, nose or throat?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Is any person to be insured now pregnant?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Was this interview conducted in a language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate language used and provide Name/address/relationship of interpreter to proposed insured.		Language: _____ _____ _____					

6. Details to Questions Answered "Yes" in Section C(5), Questions A-D Attach additional sheet(s) as necessary					
First Name	Question No.	Treatment Date	Ailment	Treatment	Name, Address, Phone No. of Medical Doctor

7. Cash with application If none, check "None" <div style="text-align: right; margin-top: 10px;"> <input type="checkbox"/> None \$ _____ </div>	Applicant's Name (Print) _____
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(Section D)

AGREEMENT / AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION / OPT OUT OF DISCLOSURE OF NONPUBLIC INFORMATION / ACKNOWLEDGEMENT

I (We) have read the above questions and answers. They are complete and true to the best of my (our) knowledge and belief. I (We) agree that this Application and the Answers to the Medical Examiner, if any, shall be attached to and form a part of any policy issued. I(We) understand: that no Agent or Medical Examiner may accept risks or pass upon insurability; make or change contract; waive any of Farmers and Traders Life Insurance Company's (the Company) rights or requirements; that the application will be approved or declined within (60) days, or I (We) will be given the reason for any further delay. That no contract shall take effect unless; the policy has been accepted by me (us); and the first premium has been paid during the continued insurability of all persons proposed for coverage. (Exception: to the extent provided in the Conditional Receipt if a premium has been paid and such Conditional Receipt Issued.) **I understand that omissions or material misstatements in this application could cause, during the first two years of the policy, an otherwise valid claim to be denied under any policy issued from the information submitted on this application.**

The Company, its reinsurers, insurance support organizations; and their authorized representative, may obtain medical and other information to evaluate my (our) application for insurance.

With this form or photocopy; I authorize any licensed physician; medical practitioner; hospital; clinic; or other medical or medically related facility; insurance company; the Medical Information Bureau (MIB); consumer reporting agency; or employer, that has any records or knowledge of me or my health, or of my children for whom insurance application is made, to such information to Farmers and Traders Life Insurance Company (the Company), its authorized representative (except MIB), or reinsurer.

I further authorize the Company to obtain an investigative consumer report, and / or motor vehicle report on my spouse, my children, or me, for whom insurance application is made.

Any information obtained will not be released by the Company to any person or organization, **EXCEPT*** to reinsurance companies; the MIB; other insurance companies to which I have applied for coverage; or other persons or companies performing business or legal services in connection with my application; or as may be otherwise lawfully required; or as I may further authorize. No information on HIV infection will be released.

***Opt Out**

I understand that I may opt out of this disclosure of nonpublic personal information to third parties by placing a check mark in the box below marked "Opt Out". However, the Company will make such other disclosures as are permitted by law.

Opt Out: I Opt out of disclosure of nonpublic personal information, other than disclosures as are permitted by law, by placing a checkmark in the box.

I agree that this authorization shall be valid for 30 months from the date signed. I acknowledge receipt of the Important Notice regarding investigative consumer reports, the Medical Information Bureau and the Notice of Insurance Information Practices. A copy of this authorization is available upon request. **x = Signature always required.**

Dated at _____ <div style="text-align: center; margin-top: 5px;">City and State</div>	x _____ <div style="text-align: center; margin-top: 5px;">Primary Insured's Signature - Parent or Guardian if Primary Insured is a Minor</div>
On _____ <div style="text-align: center; margin-top: 5px;">Month/Day/Year</div>	_____ <div style="text-align: center; margin-top: 5px;">Spouse's Signature if Proposed for Coverage</div>
Witnessed by x _____ <div style="text-align: center; margin-top: 5px;">Soliciting Agent</div>	_____ <div style="text-align: center; margin-top: 5px;">Applicant's Signature (owner) if other than Primary Insured. If Applicant is a Firm or Corporation, Insert its Name</div>
Countersigned by _____ <div style="text-align: center; margin-top: 5px;">Licensed Resident Agent Where Required by Statute or Regulation</div>	By _____ <div style="text-align: center; margin-top: 5px;">(Signature and Title of Officer Signing for Firm or Corporation)</div>

IMPORTANT NOTICE

**Give perforated copy to Primary Insured at time of application
This copy to remain attached to application for insurance**

**NOTICE OF INFORMATION PRACTICES
COLLECTION OF INFORMATION**

To underwrite and administer your insurance coverage properly, we must collect and evaluate enough information to establish your insurability.

You are our most important source of information. However, we may also seek information through an investigative consumer report whereby information is obtained through personal interviews with your neighbors, friends, or those with whom you are acquainted. That inquiry might include information as to your health, character, general reputation, personal characteristics and mode of living, as well as similar information concerning any member of your family proposed for coverage. You may request detailed information about the nature and scope of this report. That includes the name and address of the reporting agency from whom you may obtain a copy of any report made. Initial inquiries regarding these reports should be sent to: Farmers and Traders Life Insurance Company, 960 James Street, P.O. Box 1056, Syracuse NY 13201-1056 (the Company). We may also wish to verify the physical condition or health history of anyone proposed for coverage by contacting doctors, hospitals, clinics, or other medically related facilities that would have records or knowledge of his or her health.

DISCLOSURES BY THE COMPANY

We will not make a disclosure of your personal information to a third party without your authorization unless permitted or required by law.

ACCESS AND CORRECTION

There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in an investigative consumer report. We have also established procedures by which you may request correction, amendment, or deletion of any information in our files, which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request.

OBTAINING ADDITIONAL INFORMATION

We at the Company hope that you find this description of our information practices helpful. We take our responsibilities and your rights very seriously. If you have any further questions about the items just discussed, please write us.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential; however, the Company may send a brief, coded report to the MIB. The MIB operates an information exchange for its member companies. If you apply to another Bureau member company for life or health insurance, or file a claim for benefits, the information in your file will be available to them. You may request the MIB to disclose to you any information in your file. If you question the accuracy of the MIB file, you may seek a correction. The MIB information office address is P.O. Box 105, Essex Station, Boston, MA 02112. The telephone number is (617) 426-3660.

OPT OUT

You may opt out of the disclosure of nonpublic personal information to third parties, other than disclosures as are permitted by law, by placing a check mark in the box marker "Opt Out" on Section D of this Application for Life Insurance.

The undersigned has read and understands the information contained above.

Witnessed

by _____ _____
Soliciting Agent Date Primary Insured's Signature - Parent or Guardian if
Primary Insured is a Minor

Primary Insured's Spouse if proposed for coverage

This copy to remain attached to application for insurance

CONDITIONAL RECEIPT

THIS CONDITIONAL RECEIPT DOES NOT CREATE TEMPORARY OR INTERIM INSURANCE. UNLESS EACH AND EVERY CONDITION IS MET, NO COVERAGE WILL TAKE EFFECT PRIOR TO THE ACTUAL RECEIPT OF THE POLICY. NO PERSON IS AUTHORIZED TO CHANGE OR WAIVE ANY OF THE FOLLOWING CONDITIONS (which may apply to each person proposed for insurance in the application and to each policy applied for):

CONDITIONS

1. All medical examinations, tests, x-rays, and ECGs initially required by Farmers and Traders Life Insurance Company (the Company) must be received within 60 days from the date of the application; and
2. A payment must have been made with the application (any coverage effective shall be in force only for such fraction of one year as this payment bears to the annual premium); and
3. All proposed insureds must be acceptable as standard risks, according to the Company's underwriting rules in effect on the policy effective date.

EFFECTIVE DATE OF COVERAGE

"Effective Date" as used in this Conditional Receipt means the latest of:

1. the date of the application; or
2. the date of completion of all medical exams (not to exceed 2 exams), tests, x-rays, and ECGs initially required by the Company, or
3. the effective date requested in the application.

COVERAGE LIMITATIONS

The amount of insurance payable as the result of this Conditional Receipt, including other pending applications with the Company and any additional benefits payable as a result of accidental death, shall not exceed \$100,000 for life coverage.

AGREEMENT

If all conditions above are met, conditional insurance as provided by the terms and conditions of this receipt shall be in effect for the amount applied for up to \$100,000.

TERMINATION OF AGREEMENT

This agreement terminates on the earliest of the following dates:

1. on the date a policy is delivered to the applicant; or
2. on the 60th day after the date of this receipt; or
3. on the date the applicant receives notice that a policy cannot be issued as applied for. Unless receipt can be proven, a mailed notice will be deemed received 5 days after the mailing date.

If this Agreement terminates without issue of a policy, any payment received by the Company will be refunded.

Received from: _____, the sum of \$ _____, for life insurance coverage applied for. This receipt is not valid unless signed by a licensed agent of the Company; nor is it valid unless remittance if made by check or draft is honored on first presentation for payment.

Dated at _____ this _____ day of _____, _____
Day Month Year

x _____
Signature of Agent



IMPORTANT NOTICE

Give this copy to Primary Insured at time of application

NOTICE OF INFORMATION PRACTICES COLLECTION OF INFORMATION

To underwrite and administer your insurance coverage properly, we must collect and evaluate enough information to establish your insurability.

You are our most important source of information. However, we may also seek information through an investigative consumer report whereby information is obtained through personal interviews with your neighbors, friends, or those with whom you are acquainted. That inquiry might include information as to your health, character, general reputation, personal characteristics and mode of living, as well as similar information concerning any member of your family proposed for coverage. You may request detailed information about the nature and scope of this report. That includes the name and address of the reporting agency from whom you may obtain a copy of any report made. Initial inquiries regarding these reports should be sent to: Farmers and Traders Life Insurance Company, 960 James Street, P.O. Box 1056, Syracuse NY 13201-1056 (the Company). We may also wish to verify the physical condition or health history of anyone proposed for coverage by contacting doctors, hospitals, clinics, or other medically related facilities that would have records or knowledge of his or her health.

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OPT OUT

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PROPOSED INSURED'S COPY

FARMERS AND TRADERS LIFE INSURANCE COMPANY, 960 JAMES STREET, P.O. BOX 1056, SYRACUSE, NY 13201-1056
(877) 2FT-LIFE, www.ftlife.com

AGENT'S STATEMENT

This Statement is Not Part of the Application

1. The marital status of the Proposed Insured is: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
2. To your knowledge, is the policy applied for intended to replace, in whole or in part, any policy or annuity contract in force in this or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, submit required forms and explanation.			
3. Has a medical been requested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Examiner: _____ Appointment Date: _____			
4. Are you aware of any information not otherwise disclosed in the application which might have a positive or negative bearing on this risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain in Question 11.			
5. Are you aware of any other insurance application pending on the life of the Proposed Insured, whether or not written by you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list below.			
Company	Total Coverage to be Placed		
_____	_____		
_____	_____		
_____	_____		
6. How well do you know the Proposed Insured? _____ If related, please state the relationship: _____			
7. Did you detach the IMPORTANT NOTICE and give it to the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Did you personally see each person to be insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain in Question 11.			
9. List each benefit (coverage) separately, (e.g. Base Policy / Waiver of Premium / Spouse Rider)			
Benefit	Annualized Premium	Mode	Modal Premium (not annual)
Total Modal Premium:			

10. For each type of insurance, check all that apply. a. Personal: <input type="checkbox"/> Family <input type="checkbox"/> Mortgage <input type="checkbox"/> Estate Preservation <input type="checkbox"/> Other b. Business: <input type="checkbox"/> Key Person <input type="checkbox"/> Buy-sell <input type="checkbox"/> Split Dollar <input type="checkbox"/> Stock Redemption <input type="checkbox"/> Creditor <input type="checkbox"/> Other If key person: are all partners or key persons to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____ _____ If any of the Proposed Insureds have an ownership interest in the business, list Proposed Insured(s) and percent of ownership:			
11. REMARKS:			
12. Writing credit on this application shall be given to: (When splitting a case between General Agents, the General Agent listed first will be designated the "Servicing Agency" and will receive all communication from the Company.)			
	Name	Code	%*
Agency			
Agent			
Agency			
Agent			
Agency			
Agent			
* Leave blank unless a split case. % Following Agent determines % to the General Agent, and effects both compensation and production credit. Must total 100%.			
FOR HOME OFFICE USE ONLY			
Policy No. Assigned		Date & Amount Received	

I hereby declare that this application was secured by me personally and that the only commissions to be paid on any policy issued hereon shall be in accordance with agency contracts applicable thereto. I further declare that the information supplied by the insured has been truly and accurately recorded on the application, and I unqualifiedly recommend all the Proposed Insureds for insurance.

Dated at _____ on _____ x _____
City & State
Month
Day
Year
Signature of Agent