Application for $50,000 Individual Term Life Insurance Policy

[StateFarm®]

State Farm Life Insurance Company
[1 State Farm Plaza, Bloomington, IL 61710-0001]

1 Select Application Type

[X] New policy
○ Reinstatement _____

2 Personal Information - Proposed Insured

[Doe] | [John] | [J.]
Last name | First name | Middle name

[123 Main St.]
Address

[Bloomington] | [IL] | [61701] | Sex [X] Male ○ Female
City | State | ZIP Code

Marital Status [Married]

Citizenship: Are you a citizen of the United States, Canada or Mexico, or do you have a permanent Visa? [X] Yes ○ No

If No: Do you have a temporary Visa (including work or student Visa) or Temporary Protected Status (TPS)? ○ Yes [X] No

[38] Age | [03/01/1978] Date of birth (MM/DD/YYYY) | [IL] State of birth | [6' / 1"] Height (feet/inches) | [195] Weight (lbs)

[D000-0000-0000] Driver's license number | [IL] State | [000-00-0000] SSN/ITIN

3 Add Applicant/Owner Information

Complete this section if the owner is not the Proposed Insured. *Applicants/Owners are only available for Proposed Insureds ages 16-25.*

Applicant/Owner

[Doe] | [Jane] | [A]
Last name | First name | Middle name

[123 Main St.]
Address

[Bloomington] | [IL] | [61701]
City | State | ZIP Code

[000-00-0000] | [02/01/1979] | [Spouse]
SSN/ITIN | Date of birth (MM/DD/YYYY) | Relationship to Proposed Insured

[Doc type 01.01]

[StateFarm®]

Successor Owner

[Doe]	[Jill]	[A]
Last name	First name	Middle initial

[123 Main St.]
Address

[Bloomington]	[IL]	[61701]
City	State	ZIP Code

[000-00-0000]	[03/01/1994]
SSN/ITIN	Date of birth (MM/DD/YYYY)

4 Other - Life Insurance or Annuities

Replacement of Life Insurance or Annuities

This product and amount is not intended to replace other insurance. In addition, changes to or funds from another life insurance policy should not to be used to pay for this coverage. If either is planned, apply for a different product that will better meet your needs.

The following are considered replacements:

- *Discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract.*
- *Using funds from your existing policies or contracts to pay premium due on the new policy or contract.*

If Proposed Insured will not be the Owner, these questions should be completed by Applicant:

a. Do you own any life insurance or annuities on yourself or others? [X] Yes ○ No

- If yes, is the policy being applied for a replacement of any of those policies:
  - Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ○ Yes [X] No
  - Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ○ Yes [X] No

5 Riders, Dividend Options, and Premium

a. Waiver of Premium for Disability Benefit Rider [X] Yes ○ No

b. Dividend Options

Dividends are not guaranteed. Please select a dividend option from the list provided. If the selected option is unavailable, the policy provisions will determine the option.

[X] Accumulation ○ Cash ○ Reduce Premium

c. Payment Mode

[X] Annual ○ Special Monthly

6 Designate Your Beneficiaries

If additional beneficiary fields are needed, please include in Explanations, Section 12.

a. Proposed Insured

Primary Beneficiary(ies) Options

If there will be multiple primary beneficiaries, allocate equally to all primary beneficiaries: ○ Yes [X] No

If yes is selected, do not enter any beneficiary allocation below. If no, enter the desired allocations below.

[StateFarm®]

[X] **Individual**

Name (First name, Middle initial, Last name)	Address, City, State of residence, ZIP Code *(optional)*	Preferred phone number	Per Stirpes	Relationship to insured	Date of birth *(MM/DD/YYYY) (optional)*	Beneficiary Allocation %
[Jane A. Doe]	[123 Main St., Bloomington, IL 61701]	[000-000-0000]		[Spouse]	[02/01/1979]	[100%]

☐ **Estate of Insured** *(enter Beneficiary Allocation):*_____ %

☐ **Beneficiary Class** *(enter Beneficiary Allocation):*_____ %

Secondary Beneficiary(ies) Options

If there will be multiple secondary beneficiaries, allocate equally to all secondary beneficiaries: ○ Yes [X] No

If yes is selected, do not enter any beneficiary allocation below. If no, enter the desired allocations below.

☐ **Individual**

Name (First name, Middle initial, Last name)	Address, City, State of residence, ZIP Code *(optional)*	Preferred phone number	Per Stirpes	Relationship to insured	Date of birth *(MM/DD/YYYY) (optional)*	Beneficiary Allocation %

☐ **Estate of Insured** *(enter Beneficiary Allocation):*_____ %

☐ **Beneficiary Class** *(enter Beneficiary Allocation):*_____ %

7 Insurance Information

a. Have you ever had an application for life insurance declined or postponed? ○ Yes [X] No

b. In the last **three (3) years**, have you claimed or received any disability benefits because of injury or sickness? ○ Yes [X] No

If yes, are you currently disabled and unable to work? ○ Yes [X] No

8 Medical Information

a. Have you ever tested positive for or been diagnosed by a member of the medical profession with:

- Human Immunodeficiency Virus (HIV) ○ Yes [X] No
- Acquired Immune Deficiency Syndrome (AIDS) ○ Yes [X] No

9 Criminal Charges and Convictions

a. In the last **three (3) years**, have you been involved in any of the following? *Select all that apply:*

- Convicted of or pleaded guilty to any felony ☐
- Charged with a crime (with charges pending at this time) ☐
- Been on parole or probation ☐
- Incarcerated or facing incarceration as the result of a guilty plea or conviction? ☐
- None of the above [X]

b. In the past **two (2) years**, have you had your driver's license revoked, suspended, or been convicted of reckless driving or driving under the influence of alcohol or drugs? ○ Yes [X] No

10 Tobacco Use

a. Have you used any of the following tobacco or other nicotine products in any form in the last **twelve (12) months**?
Select all that apply:

- ☐ Cigarettes
- ☐ Electronic cigarettes/Vapor
- ☐ Cigars
  - How many cigars do you smoke per year? _____
- ☐ Pipe
- ☐ Chew
- ☐ Dip/Snuff
- ☐ Gum
- ☐ Patch
- ☐ Hookah pipe
- ☐ Other
- [X] None of the above

11 Additional Medical Information

a. In the last **ten (10) years**, have you been diagnosed, treated, or been given advice by a member of the medical profession for any of the following? *Select all that apply:*

- Hepatitis B ☐
- Hepatitis C ☐
- Cirrhosis of the Liver ☐
- Any disorder of the pancreas ☐
- Inflammatory bowel disease (i.e. Crohn's, Ulcerative Colitis) ☐
- Chronic Kidney Disease or Polycystic Kidney Disease ☐
- Kidney disease requiring dialysis ☐
- Bone marrow transplant ☐
- Heart transplant ☐
- Lung transplant ☐
- Kidney transplant ☐
- Liver transplant ☐
- ALS (Lou Gehrig's Disease) ☐
- Parkinson's disease ☐
- Paralysis ☐
- Multiple Sclerosis ☐
- Systemic Lupus Erythematosus ☐
- None of the above [X]

b. In the last **ten (10) years**, have you been diagnosed, treated, or been given advice by a member of the medical profession for any of the following?

- Diabetes — ○ Yes [X] No
  Are you currently or have you in the last **twelve (12) months** been treated with insulin? — ○ Yes [X] No
- Cancer or Tumor (other than Basal Cell Carcinoma or Squamous Cell Carcinoma of the skin) — ○ Yes [X] No
- Coronary Artery Disease, Congenital Heart Disorder, Heart Valve Disorder (other than Mitral Valve Prolapse), Congestive Heart Failure or Cardiomyopathy — ○ Yes [X] No
- High blood pressure — ○ Yes [X] No
  If yes: In the last **twelve (12) months**, have you received emergency treatment or hospital treatment for high blood pressure? — ○ Yes [X] No
- Any form of bleeding disorder (i.e. Hemophilia) or Anemia (other than Iron Deficiency Anemia being treated only with iron supplements) — ○ Yes [X] No

c. In the last **five (5) years**, have you been diagnosed, treated, or been given advice by a member of the medical profession for any respiratory disorder other than Asthma and/or seasonal allergies? — ○ Yes [X] No

d. In the last **five (5) years**, have you been diagnosed, treated, or been given advice by a member of the medical profession for any of the following?

- Asthma — ○ Yes [X] No
  If yes: In the last **three (3) years**, have you been hospitalized or required emergency treatment, or any time had continuous treatment with oral steroid medications for more than **thirty (30) days**? — ○ Yes [X] No
- Seizures or convulsions — ○ Yes [X] No
  If yes: When was your last seizure or convulsion?
  ○ 0-12 months ago ○ Longer than 12 months ago
- Mental or Nervous Disorder? (excluding Anxiety, Depression, and Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD)) — ○ Yes [X] No
- Anxiety — ○ Yes [X] No
  If age 26-45: In the last **five (5) years**, have you been hospitalized, had emergency treatment, or missed more than **one (1) week** of work or school? — ○ Yes [X] No
- Depression — ○ Yes [X] No
  If age 26-45: In the last **five (5) years**, have you been hospitalized, had emergency treatment, or missed more than **one (1) week** of work or school? — ○ Yes [X] No
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) — ○ Yes [X] No
  If age 26-45: In the last **five (5) years**, have you been hospitalized, had emergency treatment, or missed more than **one (1) week** of work or school? — ○ Yes [X] No

e. Have you in the last **ten (10) years**:

- Used cocaine, heroin, methamphetamine, or any other controlled substance or narcotic not prescribed by a member of the medical profession; had medical treatment or counseling for the use of prescribed or non-prescribed drugs; or been advised by a member of the medical profession to discontinue use of prescribed or non-prescribed drugs? — ○ Yes [X] No
- Had medical treatment or counseling for use of alcohol or been advised by a member of the medical profession to discontinue use of alcohol? — ○ Yes [X] No

f. Within the last **three (3) months**, have you had, or been advised to have by a member of the medical profession, any diagnostic medical tests or procedures; or have you had, or been advised to have by a member of the medical profession, any treatment or surgery (excluding the Human Immunodeficiency Virus (AIDS virus); cosmetic or orthopedic surgery and/or routine check-ups with normal results)? ○ Yes [X] No

12 Explanations

13 Agreements

Coverage will be effective as of the Policy Date if the following conditions are met: the first premium is paid when this policy is delivered; the Proposed Insured is living on the delivery date; and, on that delivery date, the information given to the Company is true and complete to the best of the Proposed Insured's and Applicant's knowledge and belief.

The Proposed Insured and the Applicant state that the information in this Application and any medical history is true and complete to the best of their knowledge and belief. Information is not true and complete to the best of their knowledge and belief if it misrepresents or omits a fact which the Proposed Insured or the Applicant knew or should have known, regardless whether the misrepresentation or omission was intentional. It is agreed that the Company can investigate the truth and completeness of such information while this policy is contestable.

By accepting this Policy, the Owner agrees to the beneficiaries named and corrections made. No change in plan, amount, benefits, or age at issue may be made on the Application unless the Owner agrees in writing. Only an authorized company officer may change the policy provisions. Neither the agent nor a medical examiner may pass on insurability.

Any policy issued on this Application will be owned by the Proposed Insured or the Applicant, if other than the Proposed Insured.

NOTICE: Insurance laws may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. The Owner should consult with legal advisors for any questions about these matters.

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

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Taxpayer Identification Number (TIN) Certification – Substitute W-9

I certify under penalties of perjury that:

(1) The TIN shown above is correct, and

(2) I am a U.S. citizen or other U.S. person (defined below), and

(3) Backup Withholding:

[X] I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding or I am exempt from backup withholding.

○ I am subject to backup withholding.

(4) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA) with respect to the account(s) for which this form has been requested because I hold or otherwise maintain the account(s) in the United States.

Definition of U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

For instructions on how to complete the form, visit the IRS website at www.irs.gov or contact your local IRS office.

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

[John J Doe] [March 1, 2016]

Proposed Insured Signature — Date (MM/DD/YYYY) — SIGNATURE

[Jane A. Doe] [March 1, 2016]

Applicant Signature — Date (MM/DD/YYYY) — SIGNATURE

Applicant's signature is not required unless Applicant is other than Proposed Insured.

[Mark Smith] [March 1, 2016]

Agent/Licensed Insurance Producer Signature — Date (MM/DD/YYYY) — SIGNATURE

At [Bloomington,] [IL]

City — State