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State Farm Life Insurance Company
One State Farm Plaza, Bloomington, IL 61710-0001

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Individual Life Insurance Application Supplement

1. Name of Proposed Insured	Birth Date	Application No.(s)

In DETAILS for "Yes" answers, IDENTIFY QUESTION NUMBER and include diagnoses, dates, durations, and names and addresses of all physicians and medical facilities. If needed, use additional sheets.

		Yes	No	DETAILS:
2.	In the last 10 years, have you been diagnosed, treated, or been given advice by a member of the medical profession for:			
	a. Disorder of eyes (other than vision correction)?	◯	◯	
	b. Dizziness, fainting, epilepsy, convulsions, seizures; frequent or severe headaches?	◯	◯	
	c. Paralysis, stroke; or disorder of the brain, spinal cord, or nerves?	◯	◯	
	d. Shortness of breath, asthma, emphysema, pneumonia, sleep apnea or other respiratory disorder?	◯	◯	
	e. Chest pain, heart attack, high blood pressure, heart murmur, or other disorder of the heart or blood vessels?	◯	◯	
	f. Hepatitis, ulcer, colitis; or other disorder of the stomach, esophagus, intestines, rectum, or liver?	◯	◯	
	g. Mental health conditions, including anxiety, depression or psychiatric disorders?	◯	◯	
	h. Diabetes, disorder of the bladder or kidneys, disorder of the thyroid, or any other endocrine disorder?	◯	◯	
	i. Sexually transmitted disease; disorder of reproductive organs; disorder of the breasts, or prostate?	◯	◯	
	j. Arthritis; deformity or amputation; or injury or disorder of the neck, back, bones or joints?	◯	◯	
	k. Cyst, tumor, or cancer?	◯	◯	
	l. Disorder of the skin or lymph glands?	◯	◯	
	m. Leukemia, anemia, immune deficiency (except for Human Immunodeficiency Virus), or any other blood disorder?	◯	◯	
	n. Recurrent fever, fatigue, or night sweats?	◯	◯	
3.	Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	◯	◯	
4.	To the best of your knowledge and belief, are you now pregnant? Have you ever had complications of pregnancy, including cesarean section?	◯	◯	

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		Yes	No	DETAILS:
5.	Have you, in the last 5 years:			
	a. Used cocaine, marijuana, methamphetamine, or any other controlled substance or narcotic not prescribed by a member of the medical profession?	◯	◯	
	b. Had medical treatment or counseling for use of alcohol or prescribed or non-prescribed drugs or been advised by a physician to discontinue use of alcohol or prescribed or non-prescribed drugs?	◯	◯	
6.	Other than what we've already discussed, have you, in the last 5 years:			
	a. Been diagnosed, treated or been given advice by a member of the medical profession for any mental or physical disorder not already mentioned?	◯	◯	
	b. Had or been advised to have treatment or a test (except for Human Immunodeficiency Virus), electrocardiogram, X-ray or scan in a medical facility such as a physician's office, lab, clinic, emergency room, or hospital?	◯	◯	
	c. Had surgery or been told by a member of the medical profession surgery was necessary?	◯	◯	
7.	Have you, in the last 3 years, claimed or received any benefits because of injury, sickness, or disability?	◯	◯	
8.	Have you had any unexplained change in weight in the last 12 months?	◯	◯	
9.	Have you used tobacco or any nicotine products in any form in the last 36 months?	◯	◯	
10.	In the last 5 years, have you for any reason not previously explained, had medication prescribed other than medications for cold, flu, seasonal allergies (i.e. hay fever) or birth control?	◯	◯	
11.	Who is your physician for routine care or illness?			
12.	Have you seen your physician for any reason other than what you've already mentioned?	◯	◯	
13.	Has your father, mother, or any brother or sister been diagnosed or treated by a member of the medical profession for diabetes, cancer, or heart disease before age 60?	◯	◯	

I state that all information in this Life Application Supplement and any additional sheets is true and complete to the best of my knowledge and belief. This Life Application Supplement and any additional sheets will be part of my Application.

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.

Witness to
Signature X _____ Dated On _____ (Month) , _____ (Year)

X _____
Signature of Proposed Insured