INSTRUCTIONS FOR COMPLETION OF BENEFICIARY STATEMENT AND PAYMENT OPTION ELECTION FORM

Return form to address at upper left.

BENEFICIARY STATEMEN T

- x Please print clearly when completing this form.
- x Answer all questions.
- x If there is more than o ne Beneficiary, we require a separate Beneficiary Statement signed by each Beneficiary.
- x Please attach a Certified Copy o6(i)-1(ci)-36 re W n 612th Certificatci on-1(ci)-3B re W nneficiary Statcient.
- x Sign-1(a)6(tu)1(r)7(e)-6(r)7(e)6(q)1(u)1(i)-7(r)8(e)6(d)1(o)1(n-1( )-12(P)8(a)-6(g-1(ci)-34i)-.)5( )]TJ 0 Tc 0 Tw 14.506 0 Td ( )T

6. Rel reati reonshi -9(p t)-1(o)-12(t)-1(he)-12( )-12(dec)-8(e)]TJ 0.002 Tw [(as)-8(ed)-12( )]TJ 0 Tc 0 Tw 16.867 0 Td ( )Tj 1.2

☐ Benefi reci reary

☐ Executor/Admi reni restrator/Person Resentati reve of Estate attach letters of attach -9(pt)-1(fm)24(ent)]TJ 0 Tc 0 Tw 12.67

Insured:_____ Policy #:_____

Beneficiary Name:_____

C. METHOD OF PAYMENT

If your share of proceeds is ***more than $10,000***, and you do NOT choose 1, 2, or 3 (below) – A Living Tradition Account® will be opened (See page 5 for terms and conditions of the account).

If your share of proceeds is ***less than $10,000*** and you do NOT choose 1, 2, or 3 (below) you will be paid by check.

☐ 1. Payment Contract Option - as described in the policy. A minimum of $5,000.00 required. Complete a Payment Option Election Form (431-205). Please contact your agent if you have questions.

☐ 2. Transfer Proceeds to Policy # _____ or to new application dated: _____on the life of _____

☐ 3. Change of Name of Annuitant to _____
(Available only on Annuities where the spouse is the beneficiary.
Also complete Beneficiary Designation Form 433 -64.)

D. FEDERAL INCOME TAX WITHHOLDING (Annuities Only)

I understand that I am subject to mandatory federal withholding of 20% on any funds eligible for rollover on any Keogh/Qualified or Tax Sheltered Annuity.

☐ YES, I want withholding

☐ NO, I do not want withholding
(If not checked the company is required to withhold.)

E. AUTHORIZATION FOR RELEASE OF INFORMATION

Farm Bureau Life Insurance Company ("the Company") or its reinsurers may obtain information about the deceased from: any physician, medical practitioner, pharmacy benefit managers, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person that has any records or knowledge of the deceased's personal history, physical or mental condition. The purpose is to determine eligibility for insurance proceeds. 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 investigatir12(orBT /T3(ns)-8(m)-24 or)-61(r)-6p(s)-8()-1(wb

Insured:_____ Policy #:

Insured:_____ Policy #:_____

Beneficiary Name:_____

TERMS AND CONDITIONS

FARM BUREAU LIFE INSURANCE COMPANY – LIVING TRADITION ACCOUNT® (For proceeds of $10,000 or more only)

A Living Tradition Account® (with a benefit of $10,000 or more), an interest bearing personal draft account will be opened for you with The Northern Trust Company, and you will promptly receive your checks. All or a portion of the funds may be utilized immediately by writing checks against that account. All check(s) and normal as6 624.913(i)-1(m)10(8pt)2(6)e4chTT45 0 bnD()36caLAIM

AUTHORIZATION FOR RELEASE OF INFORMATION (CLIENT COPY)

Farm Bureau Life Insurance Company ("the Company") or its reinsurers may obtain information about the deceased from: any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person that has any records or knowledge of the deceased's personal history, physical or mental condition. The purpose is to determine eligibility for insurance proceeds. 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 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) this revocation shall be effective ten days after receipt by the Company; (4) revoking Authorization is valid for the duration of the claim; and (5) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims and may be a basis for denying a claim for benefits or proceeds.

The company may disclose information to: its reinsurers, those who perform services for the Company or its reinsurers, and the Company's affiliates for claims handling, servicing, 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 -1(hi)3a-13(f)-13(ec13(f,)-1(6;bjz)4(2(y)16(;)-1(4uu440)-1(4uu440)-1-18(s)-3(c)- 12(en)12(l)3(t)-1(h)-12(i)3(nf)-13(or)-18()-24(a