

A Fraternal Benefit Society

Instructions Checklist for Application for Individual Life Insurance

This form is for internal and producer use only and is not part of the Application.

Do you have the correct Application?

- The Application must be the current version approved for use in the state where solicitation occurs. The application consists of:
 1. Product Details Page 770524 US 11/08 or 770148 US 10/09 (as applicable)
 2. Application for Individual Life Insurance 770230 NC 01/08
 3. Any required supplemental coverage application forms, if supplemental coverage is being applied for.

Avoid Delays

- For any explanations, where space is insufficient, you may use a separate page, which must be signed and dated by the proposed life insured and the owner, if other than the proposed life insured.
- The Signature Section is complete with all applicable signature(s).
- The Producer Report is complete.
- The producer, the proposed life insured and the owner, if other than the proposed life insured, have initialed ALL corrections.
- The appropriate Product Details Page, showing details of the certificate and riders (if any) being applied for, is complete.
- As with most legal documents, do not use white out (liquid paper) on any part of the Application.
- Notice of Information Procedures left with the proposed life insured.

Temporary Life Insurance Agreement (TIA)

- Do not complete the TIA Questions section or the TIA Agreement if you know that the pre-conditions, shown in the TIA Agreement (page 9), will not be met, however the TIA Acknowledgement section must be completed in all cases.
- The TIA Questions section of the Application and, if applicable, the TIA itself have been completed.
- If the Pre-Conditions to the TIA are met, including the first payment being made by an acceptable method, the TIA has been given to the owner.
- If the Pre-Conditions to the TIA are not met, the owner has initialed the acknowledgement accordingly and the TIA has not been left with the owner.

Supplemental Forms/Disclosures

- Supplemental and disclosure/outline of coverage forms are complete with signature(s) (if required).
- If replacing existing insurance or an annuity, the applicable replacement form has been included (if required).
- A signed illustration has been included (if required).
- Notice of Consent for Blood and Body Fluid Testing has been included (if required).

Payment of Premiums

- Payments by check, bank draft or money order must be made out to "Foresters".
- If the initial payment is being made by check, bank draft or money order it must be dated no later than the date the Application was signed by the owner.
- If PAC has been requested, all PAC requirements have been met and PAC has been fully explained to the payer.
- If the initial premium payment is being made by PAC then the payer is aware that the PAC authorization is effective immediately.
- Cash is not permitted for the payment of premium.
- Producer cannot make premium payments (unless the proposed life insured is the producer or a dependent of the producer).
- If submitting the Application electronically, remember to include a photocopy of the void check, if one was provided for PAC purposes.

The Independent Order of Foresters ("Foresters")
789 Don Mills Road
Toronto, Canada M3C 1T9

U.S. Mailing Address:
P.O. Box 179
Buffalo, NY 14201-0179

www.foresters.com
T. 800 828 1540



A Fraternal Benefit Society

Product Details Page

This form is part of the Application for Individual Life Insurance.

Proposed Life Insured:

First name: _____ Middle name: _____ Last name: _____

Proposed Life Insured residence state: _____

Amount of life insurance applied for on the proposed life insured: \$ _____

Instructions

Indicate below the type of coverage, including rider(s), if any, being applied for. Note: An asterisk (*) indicates that a supplemental coverage application form must be completed, signed and submitted with the Application if this type of rider coverage is being applied for.

Universal Life

BIG Universal Life *(with lifetime no-lapse guarantee provision)*

Available riders (if applicable to selected plan):

Accidental death \$ _____

Children's term* \$ _____

Waiver of premium

Disability income (accident only)* \$ _____

Other rider(s)*: _____

Planned modal premium \$ _____ Initial lump sum premium \$ _____

If underwriting approval is given other than as applied for, issue the certificate as follows:

Maintain premium amount. Maintain face amount. Contact producer before issue.

Special instructions:

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Product Details Page

This form is part of the Application for Individual Life Insurance.

Proposed Life Insured:

First name: _____ Middle name: _____ Last name: _____

Proposed life insured residence state: _____

Amount of life insurance applied for on the proposed life insured: \$ _____

Instructions

Indicate below the type of coverage, including rider(s), if any, being applied for. Note: An asterisk (*) indicates that a supplemental coverage application form must be completed, signed and submitted with the Application if this type of rider coverage is being applied for.

Term Life

Term 10 year 20 year 30 year Other: _____

Available riders (if applicable to selected plan):

Accidental death \$ _____

First rewards

Waiver of premium

Children's term* \$ _____

Critical illness (accelerated death benefit)* \$ _____

Disability income coverage (only elect one type) \$ _____

Disability income (accident & sickness)* Disability income (accident only)*

If underwriting approval is not given for Disability income (accident & sickness), then automatically apply for Disability income (accident only)? Yes No

Other rider(s)* _____

If underwriting approval is given other than as applied for, issue the certificate as follows:

Maintain premium amount. Maintain face amount. Contact producer before issue.

Special instructions: _____

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Application for Individual Life Insurance

1.0 Proposed Life Insured (PLI)

First name: _____ Middle name: _____ Last name: _____

Legal Residence (No P.O. Box):

Line 1: _____

Line 2: _____

City: _____ State: _____ Zip code: _____ Years at current address: _____

Best time to call: _____ Home phone number: (____) _____ - _____ Cell phone number: (____) _____ - _____

Male Female Married Divorced Widowed Separated Single
Marital status: _____ Social security number: _____

Date of birth: _____ (mmm/dd/yyyy) Photo I.D. used to verify identity and birth date:

Birth state: _____ Birth country: _____ Driver's license number and state: _____

A citizen of the United States? Yes No Passport

If 'No', what is the country of citizenship? _____ Other government I.D.: _____

What is the visa type? _____ What was the date of arrival in the U.S.? _____
Document type and number.

Employed? Yes If 'Yes', employment is: Full time Part time Seasonal _____
If seasonal, expected return to work date? (mmm/dd/yyyy)

No If 'No', state reason: _____

Work phone number: (____) _____ - _____ Ext. _____ Years with current employer: _____ Annual income \$ _____

Occupation (include duties): _____ Net worth \$ _____

A Foresters member? No, applying for membership. Yes, certificate number(s) are: _____

2.0 Owner (Complete only if other than proposed life insured. If a contingent owner is to be named, use supplemental form.)

Address for owner: Line 1: _____

Line 2: _____ City: _____ State: _____

Owner is an individual.

First name: _____ Middle name: _____ Last name: _____

Male Female Date of birth: _____ (mmm/dd/yyyy) Birth state: _____ Birth country: _____

Home phone number: (____) _____ - _____ Social security number: _____

Relation to proposed life insured: _____

Photo I.D. used to verify identity and birth date:

Driver's license number and state: _____

Passport Other government I.D.: _____
Document type and number.

A citizen of the United States? Yes No If 'No', what is the country of citizenship? _____

If the owner is other than an individual, it is a: Corporation Partnership Trust Other: _____

Entity/Trust name: _____

If owner is a trust: Date of trust agreement: _____

Name and address of trustee: _____
(mmm/dd/yyyy)

3.0 Beneficiary Information. *(Each beneficiary designation below is revocable. If, however, a beneficiary designation is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary.)*

Name of each primary beneficiary. (Include address if different from that of proposed life insured.)	Relationship to PLI	% Share
		total must
		equal 100%
Name of each contingent beneficiary. (Include address if different from that of proposed life insured.)	Relationship to PLI	% Share
		total must
		equal 100%

4.0 Other Insurance

Does the proposed life insured have existing life, accidental death, critical illness or disability income insurance or an annuity? Yes No
 (If 'Yes', please fill in the information below. Also include information about Foresters life insurance certificate(s). Also complete state and Foresters replacement/rollover/disclosure and comparison statements. Include existing life insurance or annuities in the process of being lapsed or surrendered, and those completed within the past 13 months.)

Name of Insurer.	Life Insurance \$	Accidental Death \$	Critical Illness \$	Disability Income \$	Issue Year

Is there another life insurance application pending for the proposed life insured with Foresters or another insurer? Yes No

Will coverage be discontinued or reduced, or premium payments stopped, on existing life insurance coverage or an annuity, if the insurance applied for in this application is issued (includes military group life insurance)? Yes No

If 'Yes' to either of the two questions above, enter the details. _____

5.0 Medical Information.

Proposed life insured's:

5.1 a) Height is? feet inches b) Weight is? pounds

c) Has there been an increase or decrease of more than 10 pounds in the past year? Yes No

If 'Yes', state the reason and the amount of weight increase or decrease: _____

5.2 Primary care physician or medical practitioner is?

Name: _____ Phone number: () -

Address: _____

5.3 a) Date of last consultation with a physician/medical practitioner was? _____
(mmm/dd/yyyy)

b) Reason for, and result of, consultation was? _____

c) Last consultation was with primary care physician/medical practitioner named in 5.2 above? Yes No

If 'No', the last consultation was with the following physician/medical practitioner:

Name: _____ Phone number: () -

Address: _____

6.0 General Information and Lifestyle, Tobacco/Nicotine & Substance Use Questions.

Does/Has/Is the proposed life insured:

- | | Yes | No | | |
|--|-----------------------|-----------------------|--|-----------------------|
| 6.1 Ever applied for life, critical illness or disability insurance and been turned down, postponed or withdrawn the application? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Required
Supple-
mental
Form
Completed | |
| 6.2 Have an application, formal inquiry or reinstatement request for life, critical illness or disability insurance pending with another insurer? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | |
| 6.3 Ever been asked to pay a higher premium or been issued a reduced face amount? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | |
| 6.4 An intention that a person or entity, other than the owner, will obtain a right, title or interest in a certificate issued as a result of this application (includes an intended assignment)? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | |
| 6.5 Lived in the USA or Canada less than 2 years? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | |
| 6.6 a) Lived outside of the USA or Canada at any time during the last 2 years? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | <input type="radio"/> |
| b) An intention to travel or reside outside of the USA or Canada within the next 12 months? If 'Yes':
To where? _____ When? _____
Why? _____ For how long? _____ | <input type="radio"/> | <input type="radio"/> | | |
| 6.7 In the past 10 years, had a driver's license suspended or revoked, or within the last 5 years had more than 2 moving violations? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | |
| 6.8 Ever been convicted of, incarcerated for, or pled guilty or no contest to a felony or currently charged with or on probation for a crime? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | |
| 6.9 Been placed/Currently on active duty or alert, with the Military or the Reserves? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | <input type="radio"/> |
| 6.10 In the past 12 months, piloted an aircraft or participated in hang gliding, scuba or skydiving, motorized racing, rodeo events, rock or mountain climbing or intend to participate in one or more of these or other hazardous activities or extreme sports within the next 12 months? <input type="radio"/> <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
- Provide details to all 'Yes' answers to questions 6.1 through 6.10.

Question number.	Details

- 6.11 Ever used tobacco or another product that contains nicotine?
If 'Yes', complete the chart below.

Type of product.	Quantity	Frequency	Number of years.	Date last used.
<input type="radio"/> Cigarettes				
<input type="radio"/> Cigars				
<input type="radio"/> Pipe				
<input type="radio"/> Chewing				
<input type="radio"/> Patch				
<input type="radio"/> Gum				
<input type="radio"/> Other				

- 6.12 In the past 10 years, used cannabis (marijuana), steroids or a narcotic? (Narcotic includes cocaine, barbiturates, stimulants, amphetamines, and hallucinogenic drugs, whether street or prescription.)

If 'Yes', what type(s)? _____
 Amount(s) used? _____
 Date(s) last used? _____
(mmm/dd/yyyy)

- 6.13 Received or been advised to receive treatment or counseling for alcohol or narcotic abuse?
 ('Treatment' includes the professional services of a therapist, medical practitioner, physician, medical professional or practitioner of alternative medicine and also includes a weight loss or control program.)

- 6.14 Consumed alcoholic beverages?
 If 'Yes', provide type of drinks, number of occasions per week and the number of drinks consumed on those occasions.

7.0 Medical Questions

('Treatment' includes the professional services of a therapist, medical practitioner, physician, medical professional or practitioner of alternative medicine and also includes a weight loss or control program.)

Does/Has/Is the proposed life insured:

- | | Yes | No | Required
Supple-
mental
Form
Completed |
|--|-----------------------|-----------------------|--|
| 7.1 Presently taking prescription medication? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.2 Presently under treatment? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.3 Had medication, treatment or a diagnostic test prescribed or advised that has not yet been started or completed? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.4 In the past 10 years, had an exercise ECG, echocardiogram or other ultrasound, angiography, CAT or MRI scan, biopsy, endoscope, or other special screening or diagnostic test? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.5 In the past 10 years, been diagnosed as having, or received treatment for: | | | |
| a) High blood pressure, stroke, transient ischemic attack (TIA), swelling of the ankles, shortness of breath, chest pain, pressure or discomfort, angina, aneurysm, leg pain, disorder of the arteries, heart attack or murmur, irregular heartbeat, or other disorder of the heart or circulatory system? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) High levels of cholesterol or triglycerides in the blood? _____ | <input type="radio"/> | <input type="radio"/> | |
| c) Anemia, swollen glands or other disorder of the blood or lymphatic system? _____ | <input type="radio"/> | <input type="radio"/> | |
| d) Cancer, tumor, polyp, cyst, abscess, unexplained swelling or lumps? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e) Auto-immune disease or other disorder of the immune system, other than Human Immunodeficiency Virus (HIV)? _____ | <input type="radio"/> | <input type="radio"/> | |
| f) Asthma, emphysema, chronic cough, sleep apnea, coughing of blood, or other disorder of the nose, throat or lungs? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g) Chronic hepatitis, pancreatitis, diarrhea, indigestion, colitis, ileitis, abdominal pain, bleeding, bowel obstruction or chronic disease of the esophagus, stomach, gall bladder, pancreas, liver, or bowels? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h) Chronic kidney disease, kidney stones, an incident of blood in the urine, or a disorder of the bladder, kidney, prostate gland or reproductive organs? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i) A seizure, convulsion, epilepsy, paralysis, multiple sclerosis, or chronic disorder of the nervous system, brain, eyes or ears? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j) Depression, anxiety, schizophrenia or other psychiatric disorder? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| k) Arthritis or other chronic disorder of the joints, bones, muscles, skin or connective tissues? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| l) Diabetes or other disease of the pancreas, thyroid, pituitary or other endocrine glands? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7.6 Consulted with another physician/medical practitioner, other than identified in 5.2 or 5.3, in the past 5 years? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.7 Ever tested positive for HIV (Human Immunodeficiency Virus) as part of a test for obtaining insurance? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.8 Within the past 5 years applied for or received, from any source, waiver of premiums, disability income or a critical illness benefit? _____ | <input type="radio"/> | <input type="radio"/> | |
| 7.9 Had/Have a parent and/or sibling with a history of diabetes, heart attack, angina, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, ALS (Amyotrophic Lateral Sclerosis) or other hereditary disorder? _____ | <input type="radio"/> | <input type="radio"/> | |

(If 'Yes', specify the parent and/or sibling, condition and age at onset in number 7.10). (For cancer, specify type.)

7.10	Age if living.	Age at death.	Details of condition/ Cause(s) of death.	Age if living.	Age at death.	Details of condition/ Cause(s) of death.
Father				Sibling		
Mother				Sibling		

7.11 Provide details to all 'Yes' answers to questions 7.1 through 7.8.

Question number.	Condition or disease, diagnosis as advised by attending physician, treatment, present condition.	Dates of onset/ recovery. (mmm/dd/yyyy)	Physician's name, address and phone number.

8.0 Billing and Payment Information.

Payer is: Proposed life insured Owner Other (Supplemental form required.)

Pre-authorized check plan: Monthly Quarterly Semi-annually Annually

Direct Bill: Quarterly Semi-annually Annually

It is acknowledged and agreed that Foresters may change the payment modes and/or payment methods available for premium payments after a certificate comes into effect, if issued in response to this application.

How the pre-authorized check plan works: Pre-authorized checking is a debit service that provides a convenient way to make payments. If elected, pre-authorized checking allows Foresters to collect payments, by making deductions from the payer's bank account electronically on pre-determined dates, eliminating the need for checks to be written or payments to be submitted by mail. The payer should confirm deductions made from their account by reviewing the financial institution's records of their account transactions as these records will be considered receipts for payments made.

Request for Pre-Authorized Check Plan ('PAC plan')

The payer agrees, as evidenced by his or her initials below and signature in the Signature Section of this Application, that the following terms and conditions apply.

1. Foresters is authorized to draw deductions under the PAC plan from the account identified in the banking information below or another account later identified or substituted by the Payer.
2. The financial institution from which payments are to be withdrawn is authorized to treat each withdrawal by Foresters as though it was made personally by the payer.
3. Deductions will be drawn in or before the month the payment is due, however Foresters reserves the right to determine when the first deduction, if any, will be made and the amount of that deduction.
4. This PAC plan is effective immediately and will continue until terminated, which either the payer or Foresters may do at any time by written notice sent to the other specifying the termination date.
5. The PAC plan may be terminated immediately or at any time by Foresters at its sole option and discretion if a payment is not honored by the financial institution on presentation. Failure to terminate this PAC plan after a payment is not honored does not waive or prohibit Foresters right to terminate the PAC plan as set out in this authorization or prevent Foresters from terminating the PAC plan at any time.

To combine payments under this PAC plan with a currently active Foresters certificate, enter the certificate number: _____

Banking information is to be taken from: Attached void check. Check submitted with this Application.
 Information supplied below (required if no check provided).

Bank account type: Checking Savings

Financial institution's name: _____

Financial institution's address: _____

City: _____ State: _____ Zip code: _____

Transit number: _____ Account number: _____

Payer acknowledges that payments may be deducted from his/her bank account. _____
(Payer's Initials.)

9.0 Temporary Life Insurance Agreement Acknowledgement and Questions.

Temporary Life Insurance Agreement Acknowledgement.

Will the Temporary Life Insurance Agreement be left with the owner? Yes No

If 'No', owner acknowledges that there is no temporary life insurance coverage in effect. _____
(Owner's initials.)

If 'Yes', complete the rest of this section.

Temporary Life Insurance Agreement Questions.

Has the proposed life insured:

9.1 Within the past 24 months, had either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart problem, stroke or cancer? _____

Yes	No
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

9.2 Within the past 120 days, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)? _____

9.3 Within the past 120 days, had surgery performed or recommended, had or been medically advised to have a medical test or investigation which was refused to be undertaken, has not yet been undertaken or the results of which are still unknown? _____

First payment, in the amount of \$ _____, is provided by:
 Check/Bank Draft/Money Order Pre-authorized check plan (PAC) Other _____

No first payment provided (TIA Agreement not left with owner). _____
(Specify)

10.0 Agreements

“I/Me” means individually each person identified in this Application as either the proposed life insured or the owner, and the parent/legal guardian signing this Application if the proposed life insured is a juvenile. I, as evidenced by my signature in the Signature Section of this Application, have read, understand, agree, and declare:

1. I have read this Application. I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. The statements, answers, and representations contained in this Application are full, complete, and true. All statements made in this Application shall be representations and not warranties.
2. No person, including a producer, has the authority to waive the disclosure of full, complete and truthful information in response to each question in this Application. Such person also has no authority to write down an answer given to a question in this Application other than the answer that was provided to the producer.
3. Medical examination report(s) that may be required by Foresters shall form part of this Application. I will provide full, complete and true answers required in a medical examination report(s). This Application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently enacted shall form part of the entire contract with Foresters.
4. The insurance contract that Foresters issues, if at all, as a result of this Application, is conditional on there being no change in the insurability of the proposed life insured, or a child identified in this Application, if any, between the date of this Application and the date the certificate is delivered to the owner. The insurance contract issued in response to this Application, if any, comes into effect, if at all, as described in that insurance contract. Changes or corrections made to this Application by Foresters, if any, are ratified by the owner when the insurance contract issued in response to this Application, if any, comes into effect.
5. A payment provided to Foresters is not paid to Foresters unless and until the payment is honored by the financial institution of the account from which the payment is to be drawn.
6. The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. Failure to disclose all material facts may result in a loss of coverage and cancellation of the insurance contract. It is understood and agreed that these declarations are used to establish the premium rate of the insurance provided, if any, and that a material misrepresentation or untrue declaration may render the insurance contract issued, if any, voidable. All facts should be shown in this Application.
7. No producer, medical examiner or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to do either a) or b).
 - a) make, modify, or discharge an insurance contract; or
 - b) bind Foresters by making promise(s) regarding the future performance or benefit(s) of an insurance contract issued other than as specifically written in the insurance contract issued, if any, as a result of this Application.
8. Any person who knowingly and with intent to defraud Foresters, any other insurer or other person(s) files an application for insurance or 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 and subjects such person to criminal and civil penalties. In addition, Foresters may deny payment of insurance benefits if false information materially related to a claim was provided by the proposed life insured or owner.
9. The terms of the temporary coverage provided, if any, are set out on pages 9 and 10 of this Application, including the pre-conditions and special limitations to temporary coverage and the amount and duration of that temporary coverage.
10. This Application is subject to and governed by the laws of the State where this Application was delivered to the owner, if an insurance contract is issued in response to this Application.
11. If the amount of a first payment submitted with this Application, by selected mode, is more than the amount of the first modal premium required for the certificate, if any, that comes into effect in response to this Application, the difference between those two amounts will be held by Foresters and applied, without interest, to the next modal premium or, at Foresters option, refunded without interest.
12. This Application, and related documents, may be sent to Foresters by electronic means, including, but not limited to, e-mail and facsimile transmission.
13. Foresters may send, to an e-mail address provided to us, if any, information about this Application, a certificate issued as a result of this Application, if any, Foresters and Foresters membership, including member benefits and events.

11.0 Authorization to Obtain and Disclose Information.

In this authorization, proposed life insured means the proposed life insured identified in this Application. Child means each child named, if any, and proposed for insurance, in this Application.

As evidenced by the signature(s) in the Signature Section of this Application, the proposed life insured, and owner, on their own behalf and on behalf of each child, authorizes Foresters and its reinsurers to obtain information about the proposed life insured and each child from any physician, medical practitioner, hospital, clinic, or medical facility; employer; other insurer or institution; consumer reporting agency, pharmaceutical reporting database; or Medical Information Bureau, Inc ("MIB, Inc.').

Foresters may obtain an investigative consumer report and records or other information available as to past, current or future diagnosis, treatment and prognosis of a physical or mental condition.

Foresters may obtain past, current or future drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. As it pertains to alcohol and drug information covered by federal regulation, this may be revoked at any time by written notice to Foresters. All action taken by Foresters before written revocation will not be affected.

Foresters may make a brief report to MIB, Inc. about the proposed life insured and each child. Foresters may disclose information to its reinsurers; those who perform services for Foresters related to an application for insurance or a claim for benefits; or those companies which the proposed life insured has applied or may apply for life or health insurance, or benefits. Disclosure may be made when required or permitted by law. This authorization shall be the consent required, whether implied or express, written or oral, by applicable law(s), including Federal and state legislation and regulations regarding the collection, retention, usage and disclosure of information about or related to the proposed life insured and each child.

This authorization is valid for two and one-half years from the date of this Application. Foresters or its authorized representatives may use an original document or a copy of this authorization to obtain information. A copy of the Notice of Information Procedures has been provided to the proposed life insured. It includes the MIB, Inc. and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

12.0 Signature Section.

Signature of proposed life insured (if the proposed life insured is not a juvenile).

Signature of owner (if other than proposed life insured).

Signature of parent/legal guardian (if the proposed life insured is a juvenile and the parent/legal guardian is not the owner).

Signature of payer (if other than owner or proposed life insured).

Each person signed at: _____
(City, State)

Each person signed on: _____
(mmm/dd/yyyy)

Producer Certification

I certify that:

- I personally, unless otherwise indicated in the Producer Report, asked all questions as written in this Application and have recorded all answers as given to me by the proposed life insured and owner.
- I have not made or agreed to make a rebate of the premium for this insurance.
- I am not aware of undisclosed information about the health habits or lifestyle of the proposed life insured and each child which might affect insurability.
- I recommend acceptance of this Application except as qualified in Remarks.
- I have made no misrepresentation(s) about the Foresters product(s) applied for in this Application. I have made no promise(s) regarding the benefit(s) or future performance of the product(s) applied for, other than as specifically written in the specific product(s) applied for in this Application.
- I have complied with all regulatory requirements applicable to this Application.
- If applicable, I have fulfilled all State and Federal requirements regarding the solicitation and sale of life insurance to active duty members of the United States military.
- If applicable, I have disclosed that this Application will be transmitted to Foresters by electronic means and that this original Application will be destroyed after successful transmission has been confirmed.
- This Application has not been altered in any way after the proposed life insured and owner, if other than the proposed life insured, signed it.

Does the proposed life insured have existing insurance or an annuity? Yes No

If 'Yes', complete state and Foresters replacement/rollover/disclosure and comparison statements. Include existing insurance or annuities in the process of being lapsed or surrendered, and those completed within the past 13 months.

Producer: _____
Print full name.

Signature.

Producer number.

Signed at: _____
(City, State)

Signed on: _____
(mmm/dd/yyyy)

13.0 Notice of Information Procedures.

This page must be given to the proposed life insured.

For purposes of this Notice the following words and phrases are defined. The word "Application" means the Application for Individual Life Insurance to which this Notice relates. "Producer" means the licensed individual who signed that Application as the producer. "We", "our", and "us" mean The Independent Order of Foresters. "You" and "your" mean individually the proposed life insured, and each child, if any, identified in that Application.

Privacy

Personal information we obtain about you is confidential. As permitted by privacy laws, we may disclose information without further authorization. This includes disclosure to consumer reporting agencies hired to prepare investigative reports and insurance companies to which you have applied for coverage or benefits. It also includes those providing services for us and those conducting bona fide actuarial, marketing or scientific studies or audits. We may also disclose information to your physician and The Medical Information Bureau ('MIB, Inc.'). Upon written request to us, we will give you more information about these procedures.

You can make a written request to review personal information about you in our certificate file. However, we will not disclose information to you that was prepared for an anticipated claim or civil or criminal proceeding. You may request a correction, amendment or deletion of the information in our files which you believe to be inaccurate or irrelevant. Upon written request, we will provide you with further information about these procedures.

Medical and Personal Information

The Underwriting process evaluates information about you to see if you qualify for the insurance you requested. The information we review may vary with the insurance applied for. We consider information about you such as your age, occupation, and health. We also consider your mode of living, avocation and other personal information.

The answers in this Application are our principal source of information. We may contact other people or institutions personally, by phone or by letter, to confirm or add to the information provided in this Application. For example, we may obtain information from a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, a producer or other Foresters representative may obtain information for us. A medical examination or laboratory tests may be requested.

In some cases, we may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character and general reputation. It may also include personal characteristics, such as health, finances, job, and mode of living. Information obtained by the agency may be kept in its file and later given to others who have a business need for it.

The Medical Information Bureau (MIB, Inc.)

MIB, Inc. is a non-profit organization of member life insurers which has an information exchange for its members. Information that is sent to MIB, Inc. by one member may be given to other

members who have a business need for it. MIB, Inc. may provide us or our reinsurers with a brief report about you.

Upon your written request, MIB, Inc. will arrange for disclosure of information it may have in its file about you. If you question the accuracy of MIB, Inc.'s information, you may request a correction according to the procedures in the Federal Fair Credit Reporting Act. Send these requests to

MIB, Inc.

50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

www.mib.com.

Their phone number is 866-692-6901 (TTY 866 346-3642).

If we order an investigative consumer report, it may include information obtained through interviews with your neighbors, friends or others you know. You may request a personal interview with the agency and they will make a reasonable attempt to talk to you. It will include that information in its report. The Federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from Foresters about the nature and scope of an investigation, if one is made. We will provide the name, address, and phone number of any agency we ask to prepare such a report. You may contact the agency directly to learn about the contents of the report. You may also request a copy of the report. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for Acquired Immune Deficiency Syndrome (AIDS) information.

We hope this notice helps explain our underwriting process. If you have additional questions, discuss them with your producer or contact us directly. Write to:

Foresters, Chief Underwriter
789 Don Mills Road
Toronto, Canada M3C 1T9

US Mailing Address
PO Box 179
Buffalo, NY 14201-0179

Producer name _____

Office phone number _____

14.0 Temporary Life Insurance Agreement (To be completed and left with the owner if all pre-conditions are met.)

Definitions.

For purposes of this Temporary Life Insurance Agreement (“Agreement”): “Application” means the Application for Individual Life Insurance of which this Agreement forms a part. “Producer” means the licensed individual who signed the Application as the producer. “Proposed Life Insured” means the person identified as the proposed life insured in the Application. “Owner” is identified in the “Owner” section of the Application.

Pre-Conditions to Temporary Coverage.

Subject to the terms of this Agreement, Foresters agrees to provide the temporary coverage set out in this Agreement, effective on the date the Application is signed by the owner, if each of the following pre-conditions are met:

1. The proposed life insured is not age 71 or older on the date the Application is signed by the owner.
2. No more than \$1,000,000 insurance coverage on the life of the proposed life insured is applied for in the Application, calculated by including the amount of the benefit applied for under a rider (except common carrier accidental death coverage if any) payable in the event of death of the proposed life insured.
3. All questions in this Agreement are answered ‘No’ and the ‘No’ answers shown to the questions in this Agreement are truthful.
4. No later than the date the Application is signed by the owner, a first payment, in an amount equal to at least a monthly premium for the insurance applied for in the Application, is provided.

If either one or more of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions.

Has the proposed life insured:

- | | | |
|---|-----------------------|-----------------------|
| | Yes | No |
| 1. Within the past 24 months, had either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart problem, stroke or cancer? _____ | <input type="radio"/> | <input type="radio"/> |
| 2. Within the past 120 days, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)? _____ | <input type="radio"/> | <input type="radio"/> |
| 3. Within the past 120 days, had surgery performed or recommended, had or been medically advised to have a medical test or investigation which was refused to be undertaken, has not yet been undertaken or the results of which are still unknown? _____ | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> First payment, in the amount of \$ _____, is provided by:
<input type="radio"/> Check/Bank Draft/Money Order <input type="radio"/> Pre-authorized check plan (PAC) <input type="radio"/> Other _____
<small>(Specify)</small> | | |
| <input type="radio"/> No first payment provided (TIA Agreement not left with owner). | | |

Amount of Temporary Coverage.

Subject to the terms of this Agreement, if all of the above pre-conditions are met and the proposed life insured dies while this Agreement is in effect, Foresters shall pay, to the beneficiary(ies), as shown in the Application, under this and all other Foresters temporary life insurance agreement(s) insuring the life of the proposed life insured, the lesser of:

1. The amount of insurance applied for in the Application on the life of the deceased proposed life insured, including the amount payable for the death of the proposed life insured under a rider applied for (except common carrier accidental death coverage if any); or
2. \$500,000.

Termination of Temporary Coverage.

Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following:

1. Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period.
2. The date an approved Foresters certificate on the life of the proposed life insured takes effect as described in that certificate, if a certificate is issued in response to the Application.
3. The date Foresters offers, as shown in Foresters records, the owner a Foresters certificate in response to, but not as applied for in, the Application.
4. The date a written or oral request to withdraw the Application is made by or on behalf of the proposed life insured or the owner.
5. The date a written or oral request to terminate this Agreement is made by or on behalf of the proposed life insured or the owner.
6. The date written notice is sent by Foresters, as shown in Foresters records, to the proposed life insured or the owner, terminating this Agreement.
7. The date written notice is sent by Foresters, as shown in Foresters records, to the proposed life insured or the owner, declining the Application.

Special Limitations

1. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Foresters liability to a refund of payment(s) made to Foresters.
2. This Agreement shall be void if the first payment, regardless of method, is not honored when presented for payment.
3. If the proposed life insured dies by suicide, whether sane or insane, Foresters liability under this Agreement is limited to a refund of the payment(s) made to Foresters.

Payment to Foresters

If a check, bank draft or money order is provided with the Application, it must be made payable to Foresters. Do not make the payee the producer or leave the payee blank.

Entire Agreement

This Agreement contains the entire terms regarding temporary coverage. No one, including the producer signing in the Signature Section of the Application, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement.

Governing Law

This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

Acknowledgement

I, the proposed life insured and owner, if other than the proposed life insured, by signing in the Signature Section of this Application, acknowledge and agree that I have reviewed, understand and accept the terms of this Temporary Life Insurance Agreement, including the pre-conditions and special limitations to temporary coverage and the amount and termination of temporary coverage.

Countersigned



George Mohacsi
President & Chief Executive Officer

Producer Report (Required).

This form is for internal use only and is not part of the Application.

Producer: Name: _____ Number: _____

Proposed life insured: First name: _____ Middle name: _____ Last name: _____

1. How long have you known the proposed life insured? _____ Years
2. Are you related to the proposed insured? Yes No
3. a) At the time the application was taken, did you see the proposed life insured and each child, if any, listed on the application? Yes No
b) Did you personally interview and complete the application in the presence of the proposed life insured? Yes No
If 'No', to either a or b, explain in Remarks below.
4. Did you personally witness each signature in the application? Yes No
If 'No', identify and provide contact information of person who obtained and witnessed the signature(s). _____
5. Did you personally review each document used to verify identity and birth date? Yes No
If 'No', identify and provide contact information of person who reviewed each document, if different than person identified in 4 above. _____
6. How was the face amount determined? _____
7. Purpose of the insurance applied for? Personal Business Other (specify): _____
8. Complete if the proposed life insured is a juvenile.
 - a) State amount of life insurance on primary care giver? _____ \$ _____
 - b) Are all brothers and sisters insured for the same amount? Yes No
 - c) Does the child live with the owner? Yes No
 - d) How long have you known the owner? _____ Years
9. What is the source of a lump sum premium payment? _____
10. Proposed life insured's e-mail address: _____
11. Proposed life insured's primary language is? English Spanish Other (specify): _____
12. Number of people under 25 years of age living in the proposed life insured's household? _____
13. Are the commissions to be split with another producer? Yes No
If 'Yes', state what the percentage should be for the producer who filled out this Application: _____ %
_____ will receive the remaining percentage.
Other producer's name and number _____
14. Certificate date shall be: Date issued To save insurance age
15. What rate class was quoted at the time of application? _____
16. Indicate which age/amount requirements you have ordered.

		Vendor	Confirmation #
Vital signs	<input type="radio"/>		
Paramedical	<input type="radio"/>		
Medical	<input type="radio"/>		
Blood profile	<input type="radio"/>		
Electrocardiogram (ECG)	<input type="radio"/>		
Inspection report	<input type="radio"/>		
Other	<input type="radio"/>		

Remarks

The Independent Order of Foresters ("Foresters")
 789 Don Mills Road
 Toronto, Canada M3C 1T9

U.S. Mailing Address:
 P.O. Box 179
 Buffalo, NY 14201-0179

www.foresters.com
 T. 800 828 1540



A Fraternal Benefit Society

Critical Illness Coverage – Application Form *(Where required, complete appropriate coverage disclosure form(s).)*

For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, "you" and "your" mean the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner.

Proposed Life Insured:

First name: _____ Middle name: _____ Last name: _____

Questions.

- | | | | | | | | | | |
|---|---|-----|----|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <p>1.0 Have you ever been diagnosed with or treated by a physician or medical practitioner for cancer, diabetes, heart attack, stroke, transient ischemic attack (TIA), end-stage kidney disease, organ transplant, paralysis, loss of 2 or more limbs, or blindness? _____</p> <p>2.0 Are you currently receiving a benefit under a type of disability insurance (including a governmental plan) or under the critical illness provisions of an insurance contract? _____</p> <p>3.0 Within the last 12 months, have you filed a claim with a governmental program or insurance company for either disability benefits or benefits on account of a critical illness? _____</p> | <table border="1" style="border-collapse: collapse;"> <tr> <td style="padding: 2px;">Yes</td> <td style="padding: 2px;">No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table> | Yes | No | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Yes | No | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | | | | | | | | |

Provide details to all 'Yes' answers to questions 1.0 through 3.0.

Question number.	Details

I understand that this Critical Illness Coverage - Application Form is part of and is subject to the Application.

 Signature of proposed life insured.

 Signature of owner (if other than proposed life insured).

 Producer's name (print full name).

 Producer number.

 Producer's signature.

Each person signed at: _____
 (City, State)

Each person signed on: _____
 (mmm/dd/yyyy)

The Independent Order of Foresters ("Foresters")
 789 Don Mills Road
 Toronto, Canada M3C 1T9

U.S. Mailing Address:
 P.O. Box 179
 Buffalo, NY 14201-0179

www.foresters.com
 T. 800 828 1540



A Fraternal Benefit Society

Disability Income Coverage – Application Form (Where required, complete appropriate coverage disclosure form(s).)

For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, "you" and "your" mean the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner.

Proposed Life Insured:

First name: _____ Middle name: _____ Last name: _____

Employment Information: Number of hours currently employed per week? _____ Number of weeks currently employed per year? _____

Is your employment scheduled to end, or have you received notice that it will end, within the next 26 weeks? Yes No

If 'Yes', how long have you held that employment? _____

Is your current occupation seasonal or temporary work? Yes No

(Seasonal or temporary work means employment that is less than 26 weeks in duration during a period of 52 consecutive weeks.)

Questions.

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1.0 In the past 6 months, have you been working full-time (minimum of 30 hours per week) and performing each and every duty of your regular occupation in the usual and customary manner? _____ | <input type="radio"/> | <input type="radio"/> |
| 2.0 For what percentage of time each week do you perform manual duties, such as pulling, pushing, or lifting items greater than 20 lbs., or operating machinery or equipment other than office equipment? _____% | | |
| 3.0 Are you currently receiving a benefit under a type of disability insurance (including a governmental plan) or under the critical illness provisions of an insurance contract? _____ | <input type="radio"/> | <input type="radio"/> |
| 4.0 Within the last 12 months, have you filed a claim with a governmental program or insurance company for either disability benefits or benefits on account of a critical illness? _____ | <input type="radio"/> | <input type="radio"/> |
| 5.0 Do you currently have a loss of any of the following: speech, hearing in both ears, sight in both eyes, use of both hands, use of both feet, or use of one hand and one foot? _____ | <input type="radio"/> | <input type="radio"/> |
| 6.0 Within the last 5 years have you been diagnosed with, treated by or consulted a physician or medical practitioner for one or more of the following conditions: impairment of eyes, impairment of the ears, disorder, deformity or pain of the spine, neck, back, arms, hands, legs, feet, or joints (including muscles or bones)? _____ | <input type="radio"/> | <input type="radio"/> |
| 7.0 Do you as a result of an accident or sickness, need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from chair to bed)? _____ | <input type="radio"/> | <input type="radio"/> |
| 8.0 Do you have any condition, including injury, which prevents or limits you from performing any of the duties of your current or regular occupation or employment? _____ | <input type="radio"/> | <input type="radio"/> |
| 9.0 In the past 3 years have you been unable to perform, for more than 5 consecutive work days, any of the duties of your regular occupation or employment? _____ | <input type="radio"/> | <input type="radio"/> |
| 10.0 Your gross income from employment during the 12 month period immediately preceding the date of this Application was? \$ _____ | | |

Provide details to all 'Yes' answers to questions 3.0 through 9.0.

Question number	Details

I understand that this Disability Income Coverage - Application Form is part of and is subject to the Application.

 Signature of proposed life insured.

 Signature of owner (if other than proposed life insured).

 Producer's name (print full name).

 Producer number.

 Producer's signature.

Each person signed at: _____
 (City, State)

Each person signed on: _____
 (mmm/dd/yyyy)



A Fraternal Benefit Society

Children's Term Coverage – Application Form

For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner."

Proposed Life Insured:

First name: _____ Middle name: _____ Last name: _____

Child(ren)'s Information (Must be child(ren) of the proposed life insured.)

	Name of child(ren) proposed for insurance (first, middle, last).	Gender (M – F)	Relationship to proposed life insured.	Birth date (mmm/dd/yyyy)	Height (ft/in)	Weight (lbs)
1.						
2.						
3.						
4.						

Child(ren)'s Medical History (Applies to each child listed above.)

("Treatment" includes the professional services of a therapist, medical practitioner, physician, medical professional or practitioner of alternative medicine and also includes a weight loss or control program.)

	Yes	No	Required Supplemental Form Completed
1.0 Is a child presently taking medication or undergoing treatment? _____	<input type="radio"/>	<input type="radio"/>	
2.0 Has a child had medication, treatment or a diagnostic test prescribed or advised that has not yet been started or completed? _____	<input type="radio"/>	<input type="radio"/>	
3.0 Has a child been diagnosed with or treated for an acquired or congenital disorder of the lungs, heart, arteries, blood, kidneys, brain, spinal cord, nerves or muscles? _____	<input type="radio"/>	<input type="radio"/>	
4.0 Does a child have a history of any of the following?			
a) Hyperactivity and/or attention deficit disorder or other behavioral disorder? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Fetal alcohol syndrome or Down syndrome or other genetic disorder? _____	<input type="radio"/>	<input type="radio"/>	
c) Anorexia, bulimia, or a suicide attempt? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Testing positive for HIV (Human Immunodeficiency Virus) as part of a test for obtaining insurance? _____	<input type="radio"/>	<input type="radio"/>	
e) Cancer, seizures, chronic hepatitis B or C, diabetes? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Provide details to all 'Yes' answers 1.0 through 4.0.

Question number.	Child's name.	Condition or disease, diagnosis as advised by attending physician, treatment, present condition.	Dates of onset/recovery. (mmm/dd/yyyy)	Physician's name, address and phone number.

I understand that this Children's Term Coverage - Application Form is part of and is subject to the Application.

Signature of proposed life insured. _____ Signature of owner (if other than proposed life insured). _____
 Producer's name (print full name). _____ Producer number. _____
 Producer's signature. _____

Each person signed at: _____ (City, State) Each person signed on: _____ (mmm/dd/yyyy)