The Independent Order of Foresters ("Foresters")
A Fraternal Benefit Society.
789 Don Mills Road, Toronto, ON, Canada M3C 1T9 F. 877 329 4631
U.S. Mailing Address: P.O. Box 179 Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Foresters Financial

Product Details (Complete and submit only if applying for term life insurance.)

Proposed Insured

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

Foresters Term Life

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

Non-medical – Strong Foundation Term Life	Medical – Your Term Life
Term: ○ 10 year ○ 15 year ○ 20 year ○ 25 year ○ 30 year	Term: ○ 10 year ○ 15 year ○ 20 year ○ 25 year ○ 30 year

Charity Benefit Beneficiary Designation

The life insurance product applied for will, if issued, include a Charity Benefit. The owner can designate an eligible beneficiary for that benefit now or at any time prior to the insured's death. If an eligible beneficiary is not designated prior to the insured's death, no Charity Benefit will be paid. Eligible beneficiary means a charitable organization accredited as tax exempt under section 501(c)(3) of the Internal Revenue Code and eligible to receive a charitable contribution as defined in section 170(c) of that code, or any successor provision(s) thereto.

Charitable Organization Name: _____ Tax I.D. #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Riders (Subject to state and product availability.)

○ Accidental death: $ _____	○ Children's term: $ _____	○ Waiver of premium
○ Other rider(s): $ _____		

Remarks:

_____

_____

_____

_____

_____

_____

There may be additional Disclosure forms required before the certificate can be issued. Check the State requirements.

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

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Application for Individual Life Insurance

Proposed Insured

First name	Middle name	Last name	○ Male ○ Female
Street address		City / State / Zip	
Social security # / Home phone # / Alternate phone/Cell #		Date of birth (mmm/dd/yyyy) / State & Country of birth	

U.S. citizen? ○ Yes ○ No. If "No", immigration status: ○ Green card holder ○ Permanent resident ○ Other (provide Visa type):_____

Type of Photo I.D.: ○ Driver's license State: _____ ○ Passport ○ Other government I.D.: _____
Photo I.D. # (used to verify identity): _____

Occupation & duties: _____

○ Full time ○ Part time ○ Seasonal | Income (past 12 months): $ _____ | Active duty military or reserves? ○ Yes ○ No

Foresters member? ○ Yes ○ No, applying for membership. | Email | Primary language: ○ English ○ Spanish

Owner (Complete only if other than the proposed insured. If there is to be a contingent owner, use the Contingent Owner/Other Payer I.D. Form.)

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust		Social security # / Tax I.D. #
Street address	City / State / Zip	

Type of Photo I.D.: ○ Driver's license State: _____ ○ Passport ○ Other government I.D.: _____
Photo I.D. # (used to verify identity): _____

Relationship to the proposed insured: _____ Email: _____

Phone #	If Trust, name of Trustee	If Trust, date of Trust agreement

If Individual: ○ Male ○ Female | Date of birth (mmm/dd/yyyy) | U.S. citizen? ○ Yes ○ No. If "No", immigration status: ○ Green card holder ○ Permanent resident ○ Other (provide Visa type): _____

Beneficiary (Each beneficiary below is revocable, unless "irrevocable" is written next to the name of that beneficiary.)

	Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	% Share
Primary			
Name: Address:			Total must
Name: Address:			must
Name: Address:			100%
Contingent			
Name: Address:			Total must
Name: Address:			equal 100%

Financial Questions

1. Is there an understanding or agreement, whether in writing or not, or has an offer been made to:
   a) Borrow or be given money, or other property, to pay for or enter into the insurance contract applied for? ○ Yes ○ No
   b) Sell, transfer or assign an insurance contract issued as a result of this Application? ○ Yes ○ No
   If "Yes" to 1a or 1b, provide details. _____

For each "Yes" answer to a question in the Lifestyle, either Medical, a Rider or the Other Insurance section, providing details in the Additional Information section or completing the corresponding questionnaire may be required. For purposes of these questions, "you" and "your" mean the proposed insured, "diagnosed", "tested", "advised", "treated", "counseling" and "treatment" mean by a licensed physician or medical practitioner.

Lifestyle Questions	
2. Within the past 12 months, have you used tobacco, in any form, or another nicotine product? If "Yes", specify: ○ Cigarettes ○ Other	○ Yes ○ No
3. Within the past 5 years, have you: a) Used marijuana (more than once a week), heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or another controlled substance except as prescribed by a licensed physician or medical practitioner? b) Received or been advised to receive treatment or counseling for, or to discontinue or reduce, the use of alcohol, or a non-prescribed or prescribed drug?	○ Yes ○ No ○ Yes ○ No
4. Do you expect, within the next 2 years, to change your country of residence or to travel outside of the United States, Canada, Caribbean Islands (excluding Haiti), Western Europe, Hong Kong, Australia or New Zealand?	○ Yes ○ No
5. Within the past 2 years, have you: a) Flown, or do you intend within the next 2 years to fly, in an aircraft as a student pilot or licensed pilot? b) Engaged, or do you intend within the next 2 years to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?	○ Yes ○ No ○ Yes ○ No
6. Within the past 5 years, have you had your driver's license suspended or revoked or been convicted of or pled guilty to more than 3 moving violations or to 1 or more driving while impaired or under the influence violations?	○ Yes ○ No
7. a) Within the past 10 years, have you been convicted of or pled guilty to a felony? b) Are you currently on parole, incarcerated, or serving probation or within the past 12 months have you served probation?	○ Yes ○ No ○ Yes ○ No
PART 1: Medical Questions	
8. Your: Height (ft/in): _____ Weight (lbs): _____	
9. a) Date you last consulted a physician: _____ Physician Name: _____ Address: _____ Phone #: _____ b) Reason(s) you last consulted a physician: _____ c) Were you advised that results of that consultation were outside normal ranges?	○ Yes ○ No
10. Are you currently taking prescription medication or under treatment?	○ Yes ○ No
11. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	○ Yes ○ No
12. Within the past 2 years, have you: a) Had or been advised to have a test (other than for HIV) such as an EKG, CT scan, bone scan, MRI scan, colonoscopy, echocardiogram, angiogram, biopsy, or endoscopy? b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known?	○ Yes ○ No ○ Yes ○ No
13. Do you currently: a) Reside in a nursing home or skilled nursing facility or psychiatric facility, or are you receiving or been advised to receive, skilled nursing care, hospice care, or home healthcare for a terminal condition that is expected to result in death within the next 12 months or for a chronic condition? b) Require the use of a wheelchair due to a chronic illness or disease? c) Require assistance with any of the following activities of daily living: taking medications, bathing, dressing, eating, or toileting?	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
14. Within the past 3 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for sleep apnea, seizures or epilepsy?	○ Yes ○ No
15. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for: a) Diabetes, high blood pressure, a disease or disorder of the blood or lymphatic system, coronary artery disease, heart murmur, chest pain, irregular heartbeat, aneurysm, stroke, transient ischemic attack, congestive heart failure (CHF), a disease or disorder of the arteries or valves, peripheral vascular or arterial disease (PVD or PAD), or had a heart attack, heart surgery, heart procedure or circulatory surgery? b) Cancer (excluding skin cancer that is basal cell carcinoma), tumor, gastrointestinal bleeding, unexplained weight loss, or a disease or disorder of the pancreas or endocrine system? c) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, or a disease or disorder of the respiratory system or do you currently require the use of oxygen equipment? d) Dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, Lou Gehrig's disease (ALS), muscular dystrophy, fibromyalgia, or a disease or disorder of the brain or nervous system? e) Anxiety, depression, manic depression, bi-polar disorder, schizophrenia or a mental health disorder? f) Blood in the urine, hepatitis, Crohn's disease, Systemic Lupus, cirrhosis, or a disease or disorder of the liver, prostate, bladder, kidney, genito-urinary organs, connective tissue or the digestive or immune system (other than HIV)?	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No

PART 2: Additional Medical Questions (Complete only if applying for a medically underwritten product.)

16. Have you ever used tobacco, in any form, or another nicotine product? ○ Yes ○ No
    If "Yes", specify: Type used: _____ Date last used: _____
    If currently smoking, how many pack(s) per day? _____
17. Do you currently drink alcohol? If "Yes", specify: How many times per week? ____ How many drinks per occasion? _____ ○ Yes ○ No
18. Within the past 5 years, have you consulted a physician other than identified in question 9, or a medical practitioner, or been treated, tested or monitored in a clinic, hospital or emergency room? ○ Yes ○ No
19. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for high cholesterol? ○ Yes ○ No
20. Net worth: $ _____
21. Primary Physician Name (if different from question 9): _____
    Address: _____ Phone #: _____
22. Do you have, alive or deceased, a parent or sibling diagnosed with or treated for, prior to age 65, diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, or Alzheimer's? ○ Yes ○ No

Details to "Yes"	Age, if living	Age, at death	Details of condition / Cause of death
Father			
Mother			
Sibling(s)			

Disability Income / Waiver Rider Questions (Complete only if applying for disability income or waiver coverage.)

23. a) Hours worked per week (past 6 months): _____ b) # of weeks worked (past 12 months): _____
24. Within the past 180 days, have you been unable to work at your regular job for more than 20 consecutive days or are you currently not actively at work due to an injury or sickness? ○ Yes ○ No
25. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for arthritis or for a disease or disorder of the back, neck or musculoskeletal system? ○ Yes ○ No

Children's Term Rider Questions (Complete only if applying for children's term coverage.)

Name of child (First, Middle, Last) under 18 years old (must be a child of the proposed insured)	Gender (M or F)	Date of birth (mmm/dd/yyyy)	Height (ft/in)	Weight (lbs)	Amount of coverage in force

26. Within the past 5 years, has a child listed above:
    a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disease or disorder? ○ Yes ○ No
    b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known? ○ Yes ○ No
    If "Yes", to either question 26a or 26b, complete the chart below.

Question #	Name of child	Diagnosis, date(s), treatment, present condition	Physician's name, address and phone #

Additional Information (Explain all "Yes" answers where applicable.)

Include Question #, diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone #s.

Other Insurance (Complete required State and Foresters Replacement/Rollover/Surrender/Disclosure forms. Some states require replacement forms to be completed even if existing insurance is to be kept in force.)

27. Is there another annuity or life insurance application pending, on the life of the proposed insured, with Foresters or another insurer? ○ Yes ○ No

28. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force? ○ Yes ○ No

If "Yes", to either question 27 or 28, complete the chart below. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those lapsed or surrendered within the past 13 months.

Name of Insurer	Annuity/Life insurance $	Accidental death $	Critical illness $	Disability income (per month) $	Issue year or indicate if pending

29. Have you ever had an application for life, health, disability or critical illness insurance declined, rated or modified? ○ Yes ○ No
If "Yes", provide date: _____ and reason: _____

30. 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

Payment Information and Authorization (The planned premium quoted may change following underwriting review.)

Payer is: ○ Proposed insured ○ Owner (if other than proposed insured) ○ Other (Complete Contingent Owner/Other Payer I.D. Form)

Payment mode: ○ Monthly (not available for direct bill) ○ Quarterly ○ Semi-annually ○ Annually

First premium payment to be made by: ○ Pre-Authorized Check (PAC) ○ Check (payable to Foresters) ○ Other _____

Subsequent premium payments to be made by: ○ Pre-Authorized Check (PAC) ○ Direct Bill ○ Other _____

Preferred draft date: ○ No ○ Yes, draft on the _____ day (between 1st and 28th) of the month.

PAC banking information (including drafting first premium) to be taken from:

○ Attached void check ○ Check submitted with this Application ○ Information completed below (if no check available)

Type of account: ○ Checking ○ Savings

Name of financial institution: _____

Routing Transit #: _____ Account # : _____

PAC Authorization

The payer, by signing below, verifies that the payer is the account holder of the account identified in the PAC banking information section (above) and is permitted to provide this authorization, and agrees that: 1) Foresters is authorized to draft deductions, for premiums and/or other payments related to an insurance contract issued, if any, as a result of this Application, from that account or another account later identified or substituted by, or on behalf of, the payer, such as for additional coverage, loan repayment(s) or for premium deposit funds. 2) The financial institution from which deductions are to be drafted is authorized to treat each draft by Foresters as though it was made personally by the payer. 3) Foresters reserves the right to determine when the first deduction and each subsequent deduction, if any, will be made and the amount of each deduction. 4) If a deduction request is not honored when submitted to the financial institution Foresters may, at its sole discretion, do further resubmits for the deduction. 5) This authorization is effective immediately and will continue until terminated, which either the payer or Foresters may do at any time by written notice to the other.

This authorization must be signed by the bank account owner as his/her name appears on bank records for the account provided.

X _____
(Signature of payer)

Conversion Notification

Foresters can process a check provided for payment as a check transaction or instead take the information from the check to make a one-time electronic fund transfer from the account that the check relates to.

Temporary Life Insurance Agreement (TIA) Questions & Acknowledgement

Has the proposed insured:

1. Within the past 24 months, had either an investigation or treatment, by a physician or medical practitioner, for chest pain, heart problem, stroke, cancer or AIDS ("Investigation" does not include negative tests for HIV)? ○ Yes ○ No
2. Within the past 4 months, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)? ○ Yes ○ No
3. Within the past 4 months, had surgery performed or recommended, had or been medically advised to have a medical test (other than for HIV) or investigation, that has not yet been started or completed, or the results of which are not yet known? ○ Yes ○ No

TIA Acknowledgement: Were all of the pre-conditions to temporary coverage met?

○ No (Do not provide a check for first premium payment). The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided, authorized or collected. X _____ (Owner's initials)

○ Yes. I, the owner, understand that temporary coverage is subject to, and I had the opportunity to review, the Temporary Life Insurance Agreement. First premium payment, in the amount of $ _____, is authorized, provided or collected by (select same method chosen in the Payment Information and Authorization section):

○ Pre-Authorized Check (PAC) ○ Check ○ Other (cannot be a transfer of funds from existing life insurance or annuity contract(s))

Although the first premium payment amount shown above is subject to change following underwriting, this amount must be at least equal to the monthly premium quoted for the insurance, including each rider, applied for in this Application.

Secondary Addressee (Complete only if designating another person to receive notification regarding a possible lapse in coverage.)

First name	Middle name	Last name		○ Male ○ Female
Street address		City	State	Zip

Declarations and Agreements

"Application" means this Application for Individual Life Insurance and includes additional forms, if any, that are part of this Application. "I/Me" means individually each person identified in this Application as either the proposed insured or the owner, and the parent/legal guardian signing this Application if the proposed insured is a juvenile.

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true, to the best of my knowledge and belief. 4) If I am the owner and if the amount of life insurance applied for on the life of the proposed insured is at least $20,000, I have been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

I understand and agree that: 1) All statements made in this Application shall be representations and not warranties. 2) This Application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently amended shall form part of the entire contract if an insurance contract is issued by Foresters. 3) No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. 6) Foresters will have no liability under an insurance contract issued, if any, as a result of this Application until the date that insurance contract comes into effect, according to its terms, and then only if (a) the first premium due, for that insurance contract, is provided in full on or before the delivery date of that insurance contract and is received by Foresters from the financial institution from which it is to be collected, and (b) between the date this Application was signed and the date that insurance contract comes into effect there is no event, no diagnosed change in health, and no change in the habits or circumstances of the proposed insured, or a child if any, identified in this Application, that would require a change to an answer to a question in this Application. 7) Foresters and its subsidiaries may review, transfer and otherwise use, information provided in this Application or obtained by Foresters or its subsidiaries to assess, develop, or offer and issue to me (including post issue administration), other financial products or benefits. 8) Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identity.

I further understand and agree that: 1) Changes or corrections made to this Application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. Such changes or corrections may be made directly on this Application or by an amendment to this Application. 2) No producer, medical examiner or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to make, modify, or discharge an insurance contract. 3) This Application and related documents may be completed, signed and/or submitted to Foresters by voice and/or electronic means and if completed in paper form this original Application may be destroyed after confirmation of successful transmission. 4) Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 5) I understand that providing an email address is optional. If I have chosen to provide an email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 6) 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.