Documents Package Prepared for: **Foresters ezbiz – NMO**

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Document Name	Description	Expiration Date
770681_US_g	Application for Individual Life Insurance	12/31/2199
102129_US	Producer Certification: Sales Materials used ...	12/31/2199
104978_US	Important Notice: Replacement Of Life Insuran...	12/31/2199
101250_US	Notice and Consent for Blood or Urine Testing...	12/31/2199

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

Tips for Submitting a Foresters Application for Individual Life Insurance

- Money orders or cashier's checks are NOT permitted for the payment of initial premiums.
- Premium payments CANNOT be made by the producer (unless the proposed insured is the producer or a dependent of the producer).
- Explain to your client that if a premium is returned due to non sufficient funds, the bank could attempt to re-draft within 5 business days in order to try to successfully collect the premium.
- Make sure you have the right application and forms for the state where the application is signed. Make sure you verify product rules and state availability for the applicable state.
- We may require additional information for each "Yes" answer to a question in the Lifestyle, either Medical, or a Rider section. You can speed up the Underwriting process by completing the questionnaire that is applicable to each "Yes" answer or if an applicable questionnaire is not available by providing details in the Additional Information section. Available questionnaires are listed on the Producer Report.
- Where additional space is required, use a separate sheet of paper, which must be signed and dated by the producer, Proposed Insured and Owner, if different from the Proposed Insured.
- For medically underwritten products, you are responsible for ordering requirements (refer to the Age & Amount requirements charts in the Underwriting Guide).
- Make sure all applicable questions are answered and that the answers are legible.
- When faxing, make sure pages are straight to avoid cutting off form numbers during submission.

Checklist (The owner is the proposed insured unless the Owner section of the Application is completed.)

Proposed Insured/Owner	Payer	Producer
✔ Initialed all corrections (do not use white out), if any, and signed the Signature section *(Proposed insured and Owner)* ✔ Signed and dated any supplemental sheets of paper (if required) *(Proposed insured and Owner)* ✔ Initialed the TIA Acknowledgement (if pre-conditions not met) *(Owner only)*	✔ Signed the PAC Authorization (if applicable)	✔ Initialed all corrections, if any, and signed the Producer Certification section ✔ Signed and dated any supplemental sheets of paper (if required)
Send to Foresters	**Leave with Owner**	**Leave with Proposed Insured**
✔ Completed application, the Product Details page and the Producer Report page If applicable: ✔ First premium ✔ Void check ✔ Underwriting questionnaire(s) ✔ State and Foresters replacement/rollover/surrender/disclosure forms ✔ Completed Contingent Owner/Other Payer Identification form ✔ Signed Illustration or illustration certification form ✔ Notice and Consent for Blood and Body Fluid Testing (medically underwritten products)	✔ TIA Agreement (if pre-conditions are met) ✔ Disclosure forms (e.g. Accelerated Death Benefit Rider Disclosure) ✔ Buyer's Guide If applicable: ✔ State and Foresters replacement/rollover/ surrender forms ✔ Signed Illustration or illustration certification form	✔ Notices

Foresters Difference

- We believe in enriching lives and building strong communities – that's our purpose. It has defined us since 1874, and it helps us continually redefine what a financial services provider can do for you and your family.
- We believe that you deserve more than a financial services provider – you deserve a partner that will help you prosper and improve your community.
- Foresters is a fraternal benefit society and as such, some aspects of our ownership and beneficiary rules are different than other carriers. Be sure to read the rules found in the Toolbox/Underwriting Resources section of Foresters producer website before taking an application for Foresters products.

Questions? Go to Foresters producer website ezbiz (https://portal.foresters.biz)

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Foresters Financial

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

Proposed Insured

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

Your Term Life

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

Non-medical	Medical
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.)

○ Disability income (accident and sickness): $ _____OR ○ Disability income (accident only): $ _____

If Disability income (accident and sickness) applied for but not approved, applying for Disability income (accident only)?
○ Yes ○ No

○ Accidental death: $ _____	○ Children's term: $ _____	○ Waiver of premium

○ Other rider(s): _____

Remarks:

_____

_____

_____

_____

_____

_____

There may be additional Disclosure forms required. Check the State requirements as these forms would need to be completed before the certificate can be issued.

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

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Product Details (Complete and submit only if applying for SMART Universal Life insurance.)

Proposed Insured

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

SMART Universal Life

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

Underwriting: ○ Non-medical ○ Medical

Planned premium: $ _____ ○ Monthly ○ Quarterly ○ Semi-annually ○ Annually

Life insurance qualification test: ○ Guideline Premium Test (GPT) ○ Cash Value Accumulation Test (CVAT)	Death benefit option: ○ Level ○ Increasing
Initial lump sum premium: $ _____	Source of lump sum premium: _____

Riders (Subject to state and product availability.)

○ Accidental death: $ _____	○ Children's term: $ _____	○ Disability income (accident only): $ _____
○ Waiver of monthly deductions	○ Guaranteed purchase option	
○ Other rider(s): _____		

Complete if the proposed insured is a juvenile.

a) State amount of life insurance on primary caregiver. $ _____

b) Are all brothers and sisters insured for the same amount? If "No", state amount and reason in the Remarks section below. ○ Yes ○ No

c) Does the child live with the owner? If "No", provide reason in the Remarks section below. ○ Yes ○ No

Remarks:

_____

_____

There may be additional Disclosure forms required. Check the State requirements as these forms would need to be completed before the certificate can be issued.

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

Proposed Insured

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

Advantage Plus Whole Life

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

Plan Type: ○ Paid-up at 100 ○ 20 Pay

Underwriting: ○ Non-medical ○ Medical

Dividend Option: ○ Paid-up additions ○ Paid in cash ○ Left on deposit ○ To reduce premiums

Automatic premium loan provision elected? ("Yes" or "No" must be indicated) ○ Yes ○ No

If "Yes", overdue premium will be paid through a loan against, and for as long as there is, available cash value, if any.

If "No", the certificate's Nonforfeiture provisions will automatically apply, if premium is overdue at the end of the Grace Period, resulting in either reduced coverage or surrender.

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: $ _____	○ Disability income (accident only): $ _____
○ Guaranteed insurability	Term: ○ 10 year ○ 20 year $ _____	○ Waiver of premium

○ Flexible payment paid-up additions

Maximum annual payment amount: $ _____

Planned payment amount (by mode): $ _____

(must be the same mode as premiums for certificate)

The planned payment amount will be added to the total premium for the certificate and rider(s), if any, to determine the amount of each billing, if direct bill, or of each draft, if PAC or another automatic payment option, is elected for payment of premium.

○ Single payment paid-up additions

Planned payment amount: $ _____

Payment method:

○ Check ○ PAC (planned payment amount will be added to the amount to be drafted as first premium payment).

○ Transfer ○ Other _____

Source of payment: _____

Complete if the proposed insured is a juvenile.

a) State amount of life insurance on primary caregiver: $ _____

b) Are all brothers and sisters insured for the same amount? If "No", state amount and reason in the Remarks section below. ○ Yes ○ No

c) Does the child live with the owner? If "No", provide reason in the Remarks section below. ○ Yes ○ No

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
Name: Address:			must equal
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.

Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims, (c) supporting The Independent Order of Foresters ("Foresters") business analysis and operations and (d) record keeping and future servicing by authorized persons. In this authorization, "proposed insured", "owner" and "parent/legal guardian" mean each person identified as such in this Application. "Child" means each child named, if any, and proposed for insurance, in this Application. "Authorized persons" means reinsurers, insurance agents, agencies, and Foresters subsidiaries and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business analysis and operations. As evidenced by the signature(s) in the Signature Section of this Application, the proposed insured and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or MIB, Inc. ("MIB"). This includes obtaining records or other information available as to: past, current or future diagnosis, treatment and prognosis of a physical or mental condition; past, current or future drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. Information may be disclosed: between and among Foresters and authorized persons; to companies to which the proposed insured has or may apply to for insurance coverage or benefits; as required or permitted by law. The proposed insured, and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons, to make a brief report of the proposed insured's and each child's personal and/or protected health information to MIB, even if this Application is cancelled or withdrawn. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this Application. This time limit complies with the time limit, if any, permitted by the applicable law in the state where the certificate is delivered or issued for delivery. A copy of this authorization shall be as valid as the original. Each person signing this authorization may at any time, by written notice to Foresters, revoke their authorization, except that reporting to MIB and action(s) begun before receipt of notice will not be affected. A Notices page has been provided to the proposed insured if this Application was signed in paper or will be sent electronically as part of the signed application package if this Application was signed electronically. It includes the MIB and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

Signature Section (For purposes of entire Application.)

Proposed insured's signature: **X** _____
(If the proposed insured is not a juvenile.)

Owner's signature: **X** _____
(If other than proposed insured.)

The owner or the proposed insured, if the proposed insured is the owner, signed in _____ (State) on _____ (mmm/dd/yyyy).

Parent/Legal guardian's name (print full name): _____
(If the proposed insured is a juvenile and the owner is not a parent/legal guardian.)

Parent/Legal guardian's signature: **X** _____

Producer Certification

Unless specifically stated otherwise in the Producer Report, I certify each of the following:

a) I am not aware of undisclosed information about the health, habits or lifestyle of the proposed insured or a child, identified in this Application, that might affect insurability. b) I asked the proposed insured, the parent/legal guardian if the proposed insured is a juvenile, and/or the owner each question as written in this Application to which an answer is shown, and recorded the answers as given to me by each person. c) This Application was reviewed by each person signing in the Signature Section before it was signed by that person. d) This Application has not been altered in any way after the proposed insured, the parent/legal guardian if the proposed insured is a juvenile, and owner signed it. e) I complied with applicable regulatory requirements including those relating to the solicitation and sale of life insurance to active duty members of the United States military. f) If applicable, I have disclosed that this Application, if completed in paper form, may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission. g) I have made no misrepresentation(s) about 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. h) If the amount of life insurance applied for on the life of the proposed insured is at least $20,000, the owner has been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

Will the certificate applied for be a replacement for, or a change to, existing life insurance or an annuity? ○ Yes ○ No

Are you related to the proposed insured? ○ Yes ○ No

Did you personally meet with the proposed insured and owner and review the document(s) used to verify identity and birth date of each person? ○ Yes ○ No

Producer's name (print full name): _____ Producer #: _____

Producer's signature: **X** _____ Date: _____ (mmm/dd/yyyy)

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Temporary Life Insurance Agreement (TIA) (Complete and leave with the owner only if all pre-conditions are met.)

Definitions - "Application" means the Application for Individual Life Insurance to which this Agreement relates. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters. "Producer" means the person who signed the Application as the producer. "Proposed Insured" and "Owner" mean the person(s) identified as such in the Application.

Pre-Conditions to Temporary Coverage - Subject to the terms of this Agreement, we agree 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 insured is not, on that date, less than 15 days old or age 71 or older. 2) No more than $1,000,000 of life insurance on the proposed insured is applied for in the Application, not including coverage or benefits, if any, to be provided by rider(s), whether applied for or not. 3) Each question in the Temporary Life Insurance Agreement (TIA) Questions section is answered "No" and each "No" answer shown is truthful and 4) No later than the date the Application is signed by the owner, first payment, at least equal to a monthly premium quoted for the insurance, including each rider, applied for in the Application, is provided or authorized by a method other than a transfer of funds from existing life insurance or annuity contract(s). If one or more of the above pre-conditions are not met, no temporary coverage takes effect even if this Agreement was left with the owner.

Temporary Life Insurance Agreement (TIA) Questions

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

Amount of Temporary Coverage - Subject to the terms of this Agreement, if each of the above pre-conditions is met and the proposed insured dies while this Agreement is in effect, Foresters shall pay in total, 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 insured, the lesser of a) $500,000; and, b) the amount of life insurance coverage applied for in the Application on the deceased proposed insured, not including coverage or benefits, if any, to be provided by rider(s), whether applied for or not. No temporary coverage is provided under this Agreement for coverage or benefits, whether applied for or not, that are to be provided under a rider. If we pay under this Agreement then we will retain, if collected, or deduct from the amount payable, if not collected, an amount equal to the minimum first payment amount described in the 4th pre-condition. If we do not pay under this Agreement then the first payment amount, if collected, will be (a) applied as first premium to the certificate issued, if any, as a result of the Application, or (b) refunded, without interest, if no such certificate is issued.

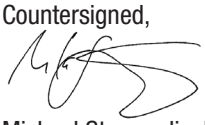
Termination of Temporary Coverage - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application 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 comes into effect as described in that certificate, if a certificate is issued in response to the Application. 3) The issue date, as shown in our records, for an approved Foresters certificate issued in response to the Application if that certificate either does not meet the conditions to come into effect, as described in that certificate, or is rescinded. 4) The date we offer, as shown in our records, the owner a Foresters certificate in response to, but not as applied for in, the Application. 5) The date a written or oral request to cancel or withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 6) The date written notice is sent by us, as shown in our records, to the owner, terminating this Agreement, cancelling or declining the Application.

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

Entire Agreement and Governing Law - This Agreement contains the entire terms regarding temporary coverage. No one, including the producer, 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. 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 insured and owner, if other than the proposed insured, by signing in the Signature Section of the Application, acknowledge and agree that I have reviewed, understand and accept the terms of this Temporary Life Insurance Agreement.

Countersigned,



Michael Stramaglia, President & Chief Executive Officer

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Accelerated Death Benefit Rider Disclosure (This disclosure must be given to the owner.)

The insurance contract you are applying for may include one of the following accelerated death benefit riders: Accelerated Death Benefit Rider (for Chronic, Critical and Terminal Illness); Accelerated Death Benefit Rider (for Critical and Terminal Illness); or Accelerated Death Benefit Rider (for Terminal Illness). You should review the insurance contract issued, if any, to determine which one of these riders, if any, it includes. This disclosure provides only a brief description of the accelerated death benefit rider ("rider") that may be included in the insurance contract; it is not the rider and only the provisions of the rider, and the certificate that the rider is attached to, will control. A full description can be found within the certificate and rider issued, if any, therefore it is important that you read the certificate and rider carefully.

Benefit Description

The rider provides the opportunity for the owner to accelerate a portion of the certificate's eligible death benefit ("acceleration amount"), during the lifetime of the insured, and receive an accelerated death benefit payment ("payment"). Under the conditions described in the rider the owner may elect to receive a payment if the insured is diagnosed, by a physician, with a chronic, critical or terminal illness, as applicable under that rider. The payment is paid to the owner and not to the beneficiary(ies). The rider is not, and is not intended to be, long-term care insurance.

There is no required premium or monthly rider deduction, as applicable, for the rider. However, a payment may have deductions and other effects, as referred to in this disclosure.

Chronic illness means the insured:

a) Is unable to perform, without substantial assistance from another person, at least two of the activities of daily living (bathing, continence, dressing, eating, toileting or transferring) for a period of at least 90 days, due to a loss of functional capacity; or

b) Requires substantial supervision by another person to protect the insured from threats to health and safety due to the insured's severe cognitive impairment.

The chronic illness must be diagnosed by a physician as permanent.

Critical illness means the insured has one or more of the following, as defined in the rider: Advanced Alzheimer's Disease (before the insured's 75th birthday), Amyotrophic Lateral Sclerosis (ALS), End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack) or Stroke.

Terminal illness means the insured has a non-correctable illness or physical condition which is reasonably expected to result in death within 12 months of diagnosis.

Amount of the Accelerated Death Benefit Payment

The accelerated death benefit payment may be less than the acceleration amount as we may deduct from the acceleration amount: an actuarial discount amount, determined by us; an administrative fee; the sum of the unpaid total premium or overdue monthly deductions, as applicable; and a loan repayment amount, if there is an outstanding loan.

For terminal illness: The actuarial discount amount and administrative fee will both be $0.00. This means that the payment will only be less than the acceleration amount if, on the effective date of the payment, there are unpaid total premiums, overdue monthly deductions or an outstanding loan amount.

For chronic and critical illness: The administrative fee will be no more than $500.00. The actuarial discount amount will be determined by us based upon a number of factors, such as the insured's age and life expectancy on the effective date of the payment, and will take into account the present value of future anticipated premiums or monthly deductions, as applicable. This means that the payment will be less, and depending on the individual circumstances of the claim could be substantially less, than the acceleration amount.

Each acceleration amount must be at least $4,500.00 and must be such that after acceleration a residual face amount of at least $10,000.00 remains. The total of all acceleration amounts cannot exceed the lesser of 95% of the eligible death benefit on the effective date of the first payment and $500,000.00. For chronic illness the maximum amount that can be accelerated in any 12 month period is 24% of the eligible death benefit on the effective date of the first payment due to a chronic illness. For critical and terminal illness, the maximum amount that can be accelerated is 95% of the eligible death benefit on the effective date of the payment.

Effect of Payment on the Certificate

An accelerated death benefit payment will not end the certificate, however it will reduce the face amount and the amount, if any, of the paid-up additional insurance, account value or cash value, and loan amount on a pro-rata basis, based upon the acceleration amount. That payment will reduce the death benefit payable, if any, to the beneficiary(ies). The reduction to the face amount for chronic and critical illness will be more, and for terminal illness may be more, than the amount of the payment. Premiums or monthly deductions due, and dividends credited, after the effective date of the payment, will be adjusted based upon the reduced face amount. The adjusted premiums or monthly deductions, if any, will be as if the certificate had been issued at the reduced face amount.

The following example is hypothetical and is intended only to show the relationship between certificate values before and after payment of an accelerated death benefit. The example is based upon a whole life insurance certificate where an acceleration amount of 50% of the eligible death benefit has been approved.

	Before Acceleration	**After Acceleration**
Face Amount:	$100,000.00	$50,000.00
Amount of Paid-up Additional Insurance:	$ 20,000.00	$10,000.00
Eligible Death Benefit:	$120,000.00	$60,000.00
Cash Value:	$30,000.00	$15,000.00
Cash Value of Paid-up Additional Insurance:	$10,000.00	$ 5,000.00
Loan Amount:	$ 8,000.00	$ 4,000.00
Cash Surrender Value:	$32,000.00	$16,000.00
Annual Premium	$ 1,272.00	$ 672.00

Effect of Payment on Taxation and Eligibility for Public Assistance

Receipt of an accelerated death benefit payment under the rider is intended to qualify for favorable tax treatment under the Internal Revenue Code. However, depending on individual circumstances or changes to that code, receipt of an accelerated death benefit payment may be a taxable event. You should consult with a qualified tax advisor in order to assess the tax impact of receiving an accelerated death benefit payment.

Receipt of an accelerated death benefit payment may affect your, your spouse's or your family's eligibility for public assistance such as Medicaid, supplemental social security income or other government benefits or entitlements. You should consult each applicable government agency before receiving an accelerated death benefit payment so that you can assess the impact on eligibility for such assistance.

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Foresters Financial

Notices (This page must be given to the proposed insured.)

For purposes of this Notice the following words and phrases are defined: "Application" means the Application for Individual Life Insurance to which this Notice relates; "Foresters", "we", "our", and "us" mean The Independent Order of Foresters; "Authorized persons" means reinsurers, insurance agents, agencies, and Foresters subsidiaries and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business analysis and operations; "Producer" means the licensed individual who signed the Application as the producer; "You" and "Your" mean individually the proposed insured, and each child, if any, identified in the Application. If you have questions regarding your application, discuss them with your producer or contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. Box 179 Buffalo, NY 14201-0179.

Privacy - Personal information we obtain about you is confidential. As permitted by privacy laws, information may be disclosed, without further authorization, between and among Foresters and authorized persons, to consumer reporting agencies hired to prepare consumer reports or consumer investigative reports, to companies to which you have applied for insurance coverage or benefits, and to those conducting bona fide actuarial, marketing or scientific studies or audits and the respective employees, agents, contractors and consultants of each of the aforementioned. We may also disclose information to your physician and MIB, Inc. ("MIB"). You can make a request to review personal information about you in our file. However, we will not disclose information to you that was prepared for an anticipated claim, civil or criminal proceeding. You may request correction of information which you believe to be inaccurate or irrelevant. Upon request, we will provide more information about these procedures.

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. 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. They may also include personal characteristics, such as health, prescription history, finances, job and mode of living. 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. We will provide the contact information of any agency we ask to prepare such a report. You may contact the agency to learn about the contents or request a copy of the report. 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. If we order a report, it may include information obtained through interviews with your neighbors, friends or others you know. 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 AIDS information.

MIB, Inc. - Information regarding your insurability will be treated as confidential. Foresters or authorized persons may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

Producer Report

Proposed Insured

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

Producer's name	Producer #	% of split

1. Indicate the anticipated rating class: _____

   If underwriting approval is for a rating class other than as anticipated, Foresters will contact you and, if we do not receive direction otherwise, the certificate will be issued to maintain face amount.

2. Should the certificate's issue date be adjusted to save the insurance age? If "Yes", additional premium may be required.	○ Yes ○ No
3. Is the proposed insured you, your spouse/partner or your child/stepchild?	○ Yes ○ No
4. In the Application, are you the owner, payer or beneficiary?	○ Yes ○ No
5. Have you submitted an additional application to Foresters on a family member of the proposed insured or owner (if other than the proposed insured)? If "Yes", list the name(s) in the Producer Comments section below.	○ Yes ○ No
6. Was a copy of the Buyer's Guide provided to the owner at the time of sale?	○ Yes ○ No

7. Indicate in the chart below if age & amount requirements were ordered (only if applying for a medically underwritten product).

Age & Amount Requirements	Vendor	Date ordered
Vitals, paramed or medical (with or without lab tests)		

Producer Comments (Can be used to provide additional information relevant to the Application and must be completed if needed to qualify statements in the Producer Certification section.)

We may require additional information for each "Yes" answer to a question in the Lifestyle, either Medical, or a Rider section. You can help speed up the Underwriting process by completing the questionnaire, from the list below, that is applicable to each "Yes" answer or if an applicable questionnaire is not available by providing details in the Additional Information section. Please refer to the Underwriting Guide for a list of all available questionnaires.

Alcohol Usage	Chest Pain	Cyst, Lump or Tumor
Diabetes	Drug and Substance Usage	Mental Health

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

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Foresters Financial

Life Insurance and Annuity Replacement Certification of Sales Material Used in Connection with Application

(Insert Serial Number)

In connection with a replacement transaction, certain State life insurance and annuity replacement regulations require that all sales materials be left with the applicant.

List by form number, all product sales materials *(print or electronic)*[1] presented to the applicant in connection with the above-referenced application:

I certify that:

a) Only The Independent Order of Foresters (Foresters™), approved sales materials referenced above were presented in connection with the above referenced application.

b) A copy of all print sales materials presented in connection with the above referenced application were left with the applicant at the time the application was completed.

c) A copy of any electronically presented materials presented in connection with the above referenced application have been or will be provided to the certificate holder in printed form no later than at the time of the certificate delivery.

d) A financial need analysis was/was not (circle one) completed based on the information provided by the applicant as reflected on the copy enclosed with the application.

Independent Producer Signature

Date (mmm/dd/yyyy)

[1] Sales Material includes, but is not limited to, a sales illustration and any other written, printed (for example, brochures) or electronically presented information created, completed or provided by Foresters or Independent Producer that is used in the presentation to the applicant which describes the benefits, features and costs of the specific product applied for.

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APPENDIX A

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

(This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

3. The existing policy or contract is being replaced because _____

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

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APPENDIX A

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

(This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

3. The existing policy or contract is being replaced because _____

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

IMPORTANT NOTICE:

To be read aloud to the applicant unless he or she has initialed the preceding page indicating he or she does not want this notice read aloud.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older -- are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

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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

HIV Antibody Test Information Form for Insurance Applicant

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 10 years.

What are the Symptoms? Most people infected with the AIDS virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever, including "night sweats"
- Weight loss for no known reason
- Swollen lymph glands in the neck, underarm, or groin area
- Fatigue or tiredness
- Diarrhea
- White spots or unusual blemishes in the mouth.

These symptoms are also symptoms of many other illnesses. They may be symptoms of AIDS only if they are not explained by other illness. Anyone with these symptoms for more than two weeks should see a doctor.

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. a) **"ELISA"** test means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus.
   b) **"Positive ELISA test"** means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.
   c) **"Western Blot Assay"** means an assay which uses reagents consisting of HIV antigens separated by polyacrylamidegel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus.
   d) **"Reactive Western Blot Assay"** means an Assay which is reactive according to the standards of performance and results specified in the manufacturer's federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.
   e) **"HIV antibody test"** means an ELISA test or a Western Blot Assay, or both.
2. **Purpose**. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
3. **Positive test results**. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.
4. **Accuracy**. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:
   a) **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   b) **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.
5. **Side effects**. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
6. **Disclosure of results**. A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician, the State Health Department, or through a local community-based organization.
7. **Confidentiality**. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.
8. **Prevention**. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

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Foresters Financial

Notice and Consent for Blood and Body Fluid Testing

To evaluate your insurability, we have requested that you provide samples of your blood and/or other body fluids for testing and analysis. Depending on your age, your medical history and the amount or the type of insurance applied for, you may be asked to provide a sample of blood and/or other body fluids, such as urine and saliva for testing and analysis. All tests will be performed by a licensed laboratory. By signing and dating this form, you agree that the testing may be done and that underwriting decisions will be based on the test results.

The tests to be performed will include a determination of the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test performed is actually a series of tests designed to determine the presence of these antibodies or antigens. If you have been infected with the HIV virus which causes AIDS, your body may have produced HIV antibodies which try to get rid of the infection.

Instead of providing a blood sample for initial testing purposes, you may be requested to first provide only a sample of your body fluids (e.g. urine or saliva) for testing. This sample of other body fluids will be tested for evidence of HIV antibodies, kidney disorders, diabetes, and foreign substances such as nicotine and cocaine. If this HIV test is abnormal (positive) or other abnormalities are ascertained, you then will be requested to provide a blood sample for full blood series testing including a confirmatory HIV blood test. Other blood tests which may be performed include determinations of blood cholesterol and related lipids (fats), and screening for diabetes, liver and kidney disorders.

Testing Considerations: Many public health organizations have recommended that before taking an HIV related test, a person seek counseling to become informed concerning the implications of such test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of a Positive Test Result: The HIV test is extremely reliable. In very rare instances, however, the test result may be abnormal (positive) in persons who are not infected with the virus. Additionally, the test result may occasionally be normal (negative) in persons who are infected with HIV, especially when the infection occurred within the previous 3 - 6 months.

While abnormal HIV test results do not mean that you have AIDS, they do mean that you are at significantly increased risk of developing AIDS or AIDS-related conditions and you may wish to consider further independent testing. Federal authorities say that persons who are HIV positive should be considered infected with the AIDS virus and capable of infecting others. An abnormal (positive) HIV blood test result or other significant blood or body fluid abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Disclosure of Test Results: All test results will be treated confidentially. The results of the test will be reported by the laboratory to us. The test results may be disclosed to employees of the IOF who have the responsibility to make underwriting decisions on behalf of us or to outside legal counsel who need such information to effectively represent us with regard to your application for insurance. The results also may be reported to our affiliates or reinsurers in connection with insurance you have applied for. In addition, if you are refused insurance because your HIV blood test is abnormal (positive), a generic code signifying non-specific blood abnormality will be reported to the Medical Information Bureau, Inc. ("MIB") as described in the notice given to you at the time of application. More specific non-HIV reports may be made to MIB in connection with testing. Test results will not otherwise be disclosed except as required by law or as authorized by you. You have the right to request the names of those specific individuals or organizations.

Notification of Test Results: If your HIV test results are normal, no notification will be sent to you. If your HIV tests are abnormal, we will contact you, your legal guardian, or the person authorized by you below. In the absence of such designation - the State Department of Health will be sent the results. Other abnormal test results which, in our opinion, are potentially significant to your health or insurability will be similarly communicated.

If you wish to preauthorize another person for notification of abnormal test results, please provide the name and address below. We encourage you to authorize a physician or other health care provider for the purpose of discussing test results:

Name and Address of Physician or Health Care Provider (Please Print): _____

Informed Consent: I have read and I understand this NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and body fluid as described above, and the disclosure of the test results as described above, including disclosure to the person, if any, indicated above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my physician or health care provider for further information and counseling if the HIV test result is abnormal. I have been given a copy of the state Hotline phone numbers and addresses (if available). I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be valid as the original.

Name of Proposed Insured	Birthdate
Signature of Proposed Insured (Parent/Guardian)	State of Residency
Date Signed by Proposed Insured (Parent/Guardian)	