



## The Independent Order of Foresters ("Foresters")

### Tips for Submitting a Foresters Paper Application for Individual Life Insurance

#### Foresters Fraternal Difference

- Foresters shares its financial strength with its members by offering them more than just a financial product; eligible members also benefit from special member benefits and community involvement opportunities to help them and their families get more out of life. Use the Foresters Benefit of Membership pamphlet to share the Foresters story and make a difference.
- 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 Tools & Resources/Advanced Marketing section of ezbiz before taking an application for Foresters products.

#### How to Avoid Delays and Get PAID Fast

- 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
- Available questionnaires are listed in the Producer Report. Complete the applicable questionnaire at the time of application for each "Yes" answer in the Lifestyle and Medical Questions sections or advise the proposed insured that Foresters may contact them for further details. Where there's no corresponding questionnaire for a "Yes" answer, provide the details in the "Additional Information" section
- To avoid potential shortages we recommend quoting standard rates, as applicable
- Premium payments cannot be made by the producer (unless the proposed insured is the producer or a dependent of the producer)
- For Universal Life applications only, the signed illustration must match exactly to what is issued. Otherwise commissions will be paid when a signed illustration matching the issued certificate, is returned to Foresters
- For explanations, where space is insufficient, 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
- If submitting an application through the Point Of Sale process (POS), refer to the POS Reference Guide on ezbiz for instructions

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

| Owner  | Payer  | Producer  |
|--|--|---|
| <ul style="list-style-type: none"> <li>✓ Initialed all corrections (do not use white out), if any, &amp; signed the Signature section</li> <li>✓ Initialed the TIA Acknowledgement (if pre-conditions not met)</li> <li>✓ Signed &amp; dated any supplemental sheet of paper, if required</li> </ul>   | <ul style="list-style-type: none"> <li>✓ Signed the Payment Information section</li> </ul>   | <ul style="list-style-type: none"> <li>✓ Initialed all corrections, if any, &amp; signed the Producer Certification section</li> <li>✓ Signed &amp; dated any supplemental sheet of paper, if required</li> </ul> |
| Send to Foresters  | Leave with Owner   | Leave with Proposed Insured   |
| <ul style="list-style-type: none"> <li>✓ Completed application, the Product Details page and the Producer Report</li> <li>If applicable:                             <ul style="list-style-type: none"> <li>✓ First premium</li> <li>✓ Underwriting questionnaire(s)</li> <li>✓ State and Foresters replacement/rollover/surrender/disclosure forms</li> <li>✓ Notice of Consent for Blood and Body Fluid Testing</li> <li>✓ Completed Contingent Owner/Other Payer Identification form</li> <li>✓ Void check</li> <li>✓ Illustration</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>✓ TIA Agreement (if pre-conditions are met)</li> <li>✓ Disclosure forms (if required)</li> <li>✓ Buyer's Guide</li> </ul> | <ul style="list-style-type: none"> <li>✓ Notices</li> </ul>   |



## The Independent Order of Foresters ("Foresters")

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

#### Proposed Insured

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Last name: \_\_\_\_\_

#### Lifefirst Term Life

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

Term:  10 year  20 year  30 year

#### 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:

\$ \_\_\_\_\_

Critical illness (accelerated death benefit):

\$ \_\_\_\_\_

First rewards

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.



## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for universal life insurance with lifetime no-lapse guarantee provision.)

|                         |                    |                  |
|-------------------------|--------------------|------------------|
| <b>Proposed Insured</b> |                    |                  |
| First name: _____       | Middle name: _____ | Last name: _____ |

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

|   |                                      |                                     |                                 |
|---|--------------------------------------|-------------------------------------|---------------------------------|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____ | Planned premium: _____               | <input type="radio"/> Monthly       | <input type="radio"/> Quarterly |
|   |                                      | <input type="radio"/> Semi-annually | <input type="radio"/> Annually  |
| Initial lump sum premium:<br>\$ _____                                     | Source of lump sum premium:<br>_____ |                                     |                                 |

|  |  |  |
|--|--|--|
| <b>Riders (Subject to state and product availability.)</b> |  |  |
| <input type="radio"/> Accidental death:<br>\$ _____        | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Waiver of premium                    | <input type="radio"/> Other rider(s): _____        |  |

|   |                                  |
|---|----------------------------------|
| <b>Remarks:</b>   | _____<br>_____<br>_____<br>_____ |
| 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. |                                  |



## The Independent Order of Foresters ("Foresters")

### 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:<br>\$ _____   | Planned premium: _____<br><input type="radio"/> Monthly <input type="radio"/> Quarterly<br><input type="radio"/> Semi-annually <input type="radio"/> Annually |
| Life insurance qualification test:<br><input type="radio"/> Guideline Premium Test (GPT)<br><input type="radio"/> Cash Value Accumulation Test (CVAT) | Death benefit option:<br><input type="radio"/> Level<br><input type="radio"/> Increasing  |
| Initial lump sum premium:<br>\$ _____   | Source of lump sum premium:<br>_____  |

#### Riders (Subject to state and product availability.)

|   |  |  |
|---|--|--|
| <input type="radio"/> Accidental death:<br>\$ _____ | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Waiver of monthly deductions  |  | <input type="radio"/> Guaranteed purchase option                     |
| <input type="radio"/> 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.



# The Independent Order of Foresters ("Foresters")

## Application for Individual Life Insurance

| Proposed Insured   |  |                    |  |  |      |
|--|--|--------------------|--|--|------|
| First name:  |  | Middle name:       |  | Last name:   |      |
|  |  |                    |  | <input type="radio"/> Male<br><input type="radio"/> Female                       |      |
| Street address (cannot be a P.O. Box.):  |  |                    | City:  | State:   | Zip: |
| Home phone #:  | Alternate phone # / Cell #:  | Best time to call: | Date of birth (mmm/dd/yyyy):   | State & Country of birth:  |      |
| Social Security #:   | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |                    |  | Primary language:<br><input type="radio"/> English <input type="radio"/> Spanish |      |
| Type of Photo I.D. (used to verify identity):<br><input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government ID: _____<br>Photo I.D. # _____ |  |                    |  |  |      |
| Occupation & duties:   |  |                    | <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Seasonal |  |      |
| Hours worked per week (past 6 months): _____   |  |                    | <input type="radio"/> Income (past 12 months): \$ _____  |  |      |
| Number of weeks worked in the past 12 months: _____  |  |                    | <input type="radio"/> Net worth: \$ _____  |  |      |
| Foresters member?<br><input type="radio"/> Yes <input type="radio"/> No, applying for membership.  |  |                    | Email address (optional):  |  |      |

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

| Name of each primary beneficiary    | Relationship to proposed insured | % Share         |
|-------------------------------------|----------------------------------|-----------------|
|                                     |                                  | total           |
|                                     |                                  | must equal      |
|                                     |                                  | 100%            |
| Name of each contingent beneficiary | Relationship to proposed insured | % Share         |
|                                     |                                  | total           |
|                                     |                                  | must equal 100% |

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

|  |                              |  |                                    |      |  |
|--|------------------------------|--|------------------------------------|------|--|
| Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust: |                              |  | Social Security # / Tax I.D. #:    |      |  |
| Street address (cannot be a P.O. Box.):  |                              | City:  | State:                             | Zip: |  |
| Relationship to the proposed insured:  |                              |  | Email address (optional):          |      |  |
| Phone #:   | If Trust, name of Trustee:   |  | If Trust, date of Trust agreement: |      |  |
| If Individual  |                              |  |                                    |      |  |
| <input type="radio"/> Male<br><input type="radio"/> Female                                     | Date of birth (mmm/dd/yyyy): | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |                                    |      |  |

### Other Insurance

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

2. Does the proposed insured 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 1 or 2, complete the chart below. Also include information about Foresters life insurance or annuity certificate(s).

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

3. Has the proposed insured ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date \_\_\_\_\_ and reason \_\_\_\_\_  Yes  No

4. 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

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. Check the State requirements as these would need to be satisfied before the certificate can be issued. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those completed within the past 13 months.

For purposes of this Application, "diagnosed", "advised" and "treatment" mean by a licensed physician or medical practitioner.

### Children's 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 |
|--|-----------------|-----------------------------|----------------|--------------|-----------------------------|
|  |                 |                             |                |              |                             |
|  |                 |                             |                |              |                             |
|  |                 |                             |                |              |                             |

5. Has a child listed above:

a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease?  Yes  No

b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for Human Immunodeficiency Virus (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 5a or 5b, complete the chart below.

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

### Financial Questions

6. Is there an intention, or an arrangement, that all or part of the insurance applied for will be:

a) Paid for by borrowing, financing or receiving money or any other property?  Yes  No

b) Transferred, assigned, sold or pledged?  Yes  No

If "Yes", to either question 6a or 6b provide details. \_\_\_\_\_

7. Has the proposed insured, owner or a beneficiary arranged, been offered, or received, an inducement, fee or compensation to buy, or pay for, the insurance applied for? If "Yes", provide details. \_\_\_\_\_  Yes  No

For each “Yes” answer in the Lifestyle and Medical Questions sections additional information may be required. Completing the corresponding questionnaire or, if no corresponding questionnaire is available, providing details in the Additional Information section may help speed up the Underwriting process.

| <b>Lifestyle Questions (For these questions “You” and “Your” mean the proposed insured.)</b>   |  |
|--|--|
| 8. Have you ever used tobacco in any form, or another nicotine product? If “Yes”, specify:<br>Type used: _____ Date last used: _____<br>If currently smoking, how many pack(s) per day? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 9. Do you currently drink alcohol? If “Yes”, specify:<br>How many times per week? _____ How many drinks per occasion? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 10. Within the past 10 years have you:<br>a) Used marijuana, heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or a controlled substance except as prescribed by a licensed physician or medical practitioner?<br>b) Received or been advised to receive treatment or counseling, by a licensed physician or medical practitioner, to discontinue or reduce the use of alcohol, non-prescribed or prescribed drugs? | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |
| 11. Do you expect to travel outside of North America or change your country of residence within the next 2 years?  | <input type="radio"/> Yes <input type="radio"/> No   |
| 12. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 13. Have you, within the past 2 years, flown, or do you in the future intend to fly, in an aircraft as a student pilot, licensed pilot or crew member?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 14. Have you, within the past 2 years, engaged, or do you in the future intend to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 15. Have you ever had your driver’s license suspended or revoked or within the past 5 years had more than 3 moving violations? If “Yes”, provide date, details and State where each occurred. _____<br>_____   | <input type="radio"/> Yes <input type="radio"/> No   |
| 16. Within the past 10 years have you:<br>a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If “Yes”, provide date, details and State where each conviction occurred. _____<br>_____<br>b) Been convicted of, pled guilty to, or are you currently on probation or incarcerated for, a felony? If “Yes”, provide date(s) and reason(s). _____<br>_____                                | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |

| <b>Medical Questions (For these questions “You” and “Your” mean the proposed insured. For each “Yes” answer, provide details in the Additional Information section.)</b>  |  |
|---|--|
| 17. a) Your: Height: _____ Weight: _____<br>b) Have you had a weight change of 10 pounds or more, within the past 12 months? If “Yes”, specify: <input type="radio"/> Gain <input type="radio"/> Loss<br>How many pounds? _____ Reason: _____ | <input type="radio"/> Yes <input type="radio"/> No |
| 18. Date you last consulted a physician: _____<br>Physician Name: _____<br>Address: _____<br>a) Reason(s): _____<br>b) Were results of that consultation within normal ranges? If “No”, provide details.<br>_____<br>_____                    | <input type="radio"/> Yes <input type="radio"/> No |

|  |                |                |                                       |
|--|----------------|----------------|---------------------------------------|
| 19. Your Personal Physician(s), if different than question 18.   |                |                |                                       |
| Name: _____  |                | Address: _____ |                                       |
| Name: _____  |                | Address: _____ |                                       |
|  |                | Phone #: _____ |                                       |
|  |                | Phone #: _____ |                                       |
| 20. Within the past 5 years, have you consulted a physician other than identified in question 18 or 19, or a medical practitioner, or been a clinic, hospital or emergency room patient?   |                |                | ○ Yes ○ No                            |
| 21. Are you presently taking prescription medication or under treatment?   |                |                | ○ Yes ○ No                            |
| 22. 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                            |
| 23. Do you have, alive or deceased, a parent or sibling with a history, prior to age 65, of diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, or other hereditary disorder?                          |                |                | ○ Yes ○ No                            |
| Details to "Yes" answers to question 23.   |                |                |                                       |
|  | Age, if living | Age, at death  | Details of condition / Cause of death |
| Father   |                |                |                                       |
| Mother   |                |                |                                       |
| Siblings   |                |                |                                       |
|  |                |                |                                       |
| 24. Within the past 5 years, have you:   |                |                |                                       |
| a) Had or been advised to have a diagnostic test (other than for HIV) such as an EKG, CAT scan, MRI scan, echocardiogram, angiogram, biopsy, or endoscopy?   |                |                | ○ 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                            |
| c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?  |                |                | ○ 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:   |                |                |                                       |
| a) High blood pressure, coronary artery disease, heart murmur, chest pain, irregular heart beat, aneurysm, stroke, Transient Ischemic Attack, circulatory surgery, a disease or disorder of the arteries or circulatory system or had a heart attack or heart surgery? |                |                | ○ Yes ○ No                            |
| b) Anemia, high cholesterol, swollen glands or a disease or disorder of the blood or lymphatic system?   |                |                | ○ Yes ○ No                            |
| c) Cancer, tumor, polyp, cyst, melanoma, unexplained swelling or lump or a malignancy?   |                |                | ○ Yes ○ No                            |
| d) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, chronic cough, sleep apnea, or a disease or disorder of the respiratory system?   |                |                | ○ Yes ○ No                            |
| e) Seizures, epilepsy, dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, or a disease or disorder of the brain or nervous system?   |                |                | ○ Yes ○ No                            |
| f) Anxiety, depression, bi-polar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder (PTSD) or a mental health disorder?  |                |                | ○ Yes ○ No                            |
| g) Blood or albumin in the urine or a disease or disorder of the prostate, bladder, kidney or genito-urinary organ?  |                |                | ○ Yes ○ No                            |
| h) Diabetes, or a disease or disorder of the thyroid, pituitary, pancreas or endocrine system?   |                |                | ○ Yes ○ No                            |
| i) Hepatitis, colitis, ileitis, gastritis, ulcer, Crohn's disease or a disease or disorder of the digestive system?  |                |                | ○ Yes ○ No                            |
| j) Arthritis, fibromyalgia, or a disease or disorder of the back, neck or musculoskeletal system?  |                |                | ○ Yes ○ No                            |
| k) Lupus or a disease or disorder of the immune system (other than HIV) or connective tissue?  |                |                | ○ Yes ○ No                            |

| Additional Information (Explain all "Yes" answers from the Medical Questions section.) |   |
|--|---|
| Question #   | State diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone numbers (if different than question 19). |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |
|  |   |

## 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 Form)

### First premium payment to be made by:

Draft via Pre-Authorized Check (PAC)     Check (payable to Foresters)

### Subsequent premium payments made by:

PAC     Direct Bill

### Payment mode:

Monthly (PAC only)                       Quarterly                       Semi-annually                       Annually

### 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: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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 and agrees that: 1) Foresters is authorized to draft deductions under the PAC plan from that account or another account later identified or substituted by the payer. 2) The financial institution from which payments 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, if any, will be made and the amount of that deduction for the product issued. 4) This PAC plan is effective immediately and will continue until terminated, which either the payer or Foresters may do at any time by written notice to the other.

This agreement 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

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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

### Temporary Life Insurance Agreement (TIA) Acknowledgement

Will the TIA be left with the owner?

No. The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided or authorized.

X \_\_\_\_\_  
(Owner's initials)

Yes. Complete the TIA and leave it with the owner.

First premium payment, in the amount of \$ \_\_\_\_\_, is provided or authorized by (select same method chosen in the Payment Information and Authorization section):

- Draft via Pre-Authorized Check (PAC) plan  
 Check

Although the first 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 applied for in this Application and is payable no later than the date this Application is signed.

### Declarations and Agreements

"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 in this Application, declare that: 1) I have read 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.

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 with Foresters. 3) No person, including a producer, has the authority to waive the disclosure of full, complete and truthful information or write down an answer to a question in this Application other than the answer provided to that person. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) Failure to disclose all material facts may result in a loss of coverage and cancellation of the insurance contract. A material misrepresentation or untrue declaration may render the insurance contract issued, if any, voidable. All facts should be shown in this Application. 6) The insurance contract issued, if at all, as a result of this Application, is conditional on there being no change in the insurability of the proposed insured, or a child identified in this Application, if any, between the date this Application was signed by the proposed insured and the date that the insurance contract comes into effect, being either the issue date or delivery date of the insurance contract according to its terms. 7) Foresters may review, transfer and otherwise use, information provided in this Application to offer and issue (including post issue administration), other insurance products to me.

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, including but not limited to, email and facsimile 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) If I have chosen to provide a current internet 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 and with intent to defraud Foresters, any other insurer, or other person(s), files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.



**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 of which this Agreement forms a part. "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, Foresters agrees to provide the temporary coverage set out in this Agreement, effective on the date the Application is signed by the owner, if each of the following pre-conditions are met: 1) The proposed insured is not age 71 or older on that date. 2) No more than \$1,000,000 insurance coverage on the life of the proposed insured is applied for in the Application, calculated by including the amount of the benefit applied for under each rider (except common carrier accidental death coverage if any) that is payable in the event of death of the proposed insured. 3) Each of the Temporary Life Insurance Agreement questions are answered 'No' and the 'No' answers shown are 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 applied for in the Application, is provided or authorized. 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 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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

**Amount of Temporary Coverage** - Subject to the terms of this Agreement, if all of the above pre-conditions are met and the proposed insured dies while this Agreement is in effect, Foresters shall pay, to the beneficiary(ies), as shown in the Application, under this and all other Foresters temporary life insurance agreement(s) insuring the life of the proposed insured, the lesser of a) \$500,000; or, b) the amount of insurance applied for in the Application on the life of the deceased proposed insured, including the amount payable for the death of the proposed insured under a rider applied for (except common carrier accidental death coverage if any).

**Termination of Temporary Coverage** - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate on the life of the proposed insured takes effect as described in that certificate, if a certificate is issued in response to the Application. 3) The date Foresters offers, as shown in Foresters records, the owner a Foresters certificate in response to, but not as applied for in, the Application. 4) The date a written or oral request to withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 5) The date written notice is sent by Foresters, as shown in Foresters records, to the proposed insured or the owner, terminating this Agreement 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 Foresters liability to a refund of payment(s) made to Foresters. If the proposed insured dies by suicide, whether sane or insane, Foresters liability under this Agreement is limited to a refund of the payment(s) made to Foresters.

**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,

George Mohacsi, President & Chief Executive Officer

**Authorization To Obtain And Disclose Information**

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims and c) supporting the operations of our business. In this authorization, "proposed insured" means the proposed insured identified in this Application. "Child" means every child named, if any, and proposed for insurance, in this Application. As evidenced by the signature(s) in the Signature Section of this Application, the proposed insured, and owner, on their behalf and on behalf of each child, authorizes Foresters, its reinsurers and those who perform services for Foresters related to an application for insurance or a claim for benefits, to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; other insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or Medical Information Bureau, Inc ('MIB, Inc.'). 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. Foresters may make a brief report to MIB, Inc. about the proposed insured and each child. Foresters or its authorized representatives may disclose information to: its reinsurers; appointed producers, agencies and those who perform services for Foresters related to an application for insurance or a claim for benefits; or those companies to which the proposed insured has applied or may apply to for life or health insurance, or benefits. Disclosure may be made when required or permitted by law and the disclosed information may no longer be protected by federal privacy laws. This authorization shall be the consent required, whether implied or express, written or oral, by applicable law(s), including Federal and state legislation and regulations regarding the collection, retention, usage and disclosure of information about or related to the proposed insured, owner and each child. This authorization is valid for two years from the date of this Application. Foresters or its authorized representatives may use an original document or a copy of this authorization to obtain information. This authorization may be revoked at any time by written notice to Foresters, except that action(s) taken before written revocation will not be affected. A Notices page has been provided to the proposed insured. It includes the MIB, Inc. and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

**Signature Section (For purposes of entire Application.)**

**X** \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

**X** \_\_\_\_\_  
Signature of owner (if other than proposed insured)

**X** \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile and the owner is not a parent/guardian)

Each person signed at: \_\_\_\_\_  
(City, State.)

Each person signed on: \_\_\_\_\_  
Date (mmm/dd/yyyy.)

**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 that might affect insurability; b) I personally met with the proposed insured and each child and asked the proposed insured and/or the owner each question as written in this Application to which an answer is shown, recorded those answers given to me by the proposed insured and owner, reviewed with each this Application before it was signed by that person, reviewed the document(s) used to verify identity and birth date and witnessed each signature in this Application; c) This Application has not been altered in any way after the proposed insured and owner signed it; d) 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; e) If applicable, I have disclosed that this Application may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission; f) 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.

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

Are you related to the proposed insured?  Yes  No

\_\_\_\_\_  
Producer's full name

\_\_\_\_\_  
Producer #

**X** \_\_\_\_\_  
Signature of producer

\_\_\_\_\_  
Date (mmm/dd/yyyy)

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

For purposes of this Notice the following words and phrases are defined. The word "Application" means a Foresters application for insurance. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters. "You" and "Your" mean individually the proposed insured, and each child, if any, identified in the Application. If you have questions, discuss them with the producer who signed your application or contact us directly. Write to Foresters, Chief Underwriter 789 Don Mills Road Toronto, Canada M3C 1T9, or to our US Mailing Address at PO Box 179 Buffalo, NY 14201-0179.

**Privacy** -Personal information we obtain about you is confidential. As permitted by privacy laws, we may disclose information without further authorization to consumer reporting agencies hired to prepare consumer reports or consumer investigative reports, insurance companies to which you have applied for coverage or benefits, our reinsurers, those providing services for us including insurance producers and agencies contracted or appointed by us and 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 The Medical Information Bureau ("MIB, Inc."). You can make a written 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 written 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.

**The Medical Information Bureau (MIB, Inc.)** -Information regarding your insurability will be treated as confidential. Foresters or its reinsurers 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 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 or at www.mib.com. Foresters, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## Producer Report

### Proposed Insured

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Last name: \_\_\_\_\_

|                 |            |            |
|-----------------|------------|------------|
| Producer's name | Producer # | % of split |
| Producer's name | Producer # | % of split |
| Producer's name | Producer # | % of split |

1. Rating class applied for: \_\_\_\_\_  
 If underwriting approval is given other than as quoted, Foresters will contact you and, if we do not receive direction otherwise, the certificate will be issued to maintain face amount.

2. Indicate in the chart below if age & amount requirements were ordered.

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

3. Certificate date shall be:  Date issued  To save insurance age  
 Certificate date can be backdated to save insurance age but is subject to rules and requires all back premiums to be collected.

4. Are you related to the proposed insured? If "Yes", please state the relationship in the Remarks section below.  Yes  No

5. Have you submitted an additional application to Foresters:  
 a) On the proposed insured or owner (if other than the proposed insured)?  Yes  No  
 b) On a family member of the proposed insured or owner (if other than the proposed insured)? If "Yes", list the name(s) in the Remarks 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. If a personal health interview (PHI) was conducted as part of the application process, provide the PHI Inspection Reference ID #.  
 \_\_\_\_\_

### Remarks (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.)

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For each "Yes" answer in the Lifestyle and Medical Questions sections complete the applicable questionnaire, if one is available, at the time of Application. If no corresponding questionnaire is available or none is submitted, advise the proposed insured that Foresters may contact them to obtain further details. A list of available questionnaires is provided below.

| Lifestyle Questions Section – Questionnaires For: |  |                          |                          |                |
|---|--|--------------------------|--------------------------|----------------|
| Aerial sports                                     | Alcohol usage  | Aviation                 | Drug and Substance usage | Foreign travel |
| Hazardous Sports                                  | Military   | Mountain & Rock climbing | Scuba and Skin diving    | Tobacco        |
| Medical Questions Section – Questionnaires For:   |  |                          |                          |                |
| Activities of daily living                        | Arrhythmia / Atrial fibrillation / Irregular heartbeat |                          | Arthritis                |                |
| Attention Deficit Hyperactivity disorder          | Back & Neck  |                          | Benign prostate          |                |
| Chest pain  | Cyst, lump or tumor                                    |                          | Diabetes                 |                |
| Digestive system disorders                        | Epilepsy & Seizures disorders                          |                          | Heart murmur             |                |
| High blood pressure                               | Kidney & Urinary disorder                              |                          | Lupus                    |                |
| Mental health                                     | Prostate cancer  |                          | Respiratory disorders    |                |
| Sleep apnea / Sleep disorder                      |  |                          |                          |                |

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