

# Guide to Completing a Life Insurance Application

Strong Foundation & Your Term (Term)

SMART (Universal Life)

Advantage Plus (Whole Life)



This guide provides information on how to complete a standard Foresters Financial™ Life Insurance Application for Strong Foundation, Your Term, SMART UL, and Advantage Plus. It is **NOT** applicable for submitting:

- e-Apps
- PlanRight applications

# Application Package

- **Cover** page checklist with tips to help avoid delays
- Separate **Product Details** pages – complete and submit only the applicable product page
- **Application** for Individual Life Insurance pages
  - For base product and all riders
  - Only one signature for insured/owner and one signature for payer required in the entire application
- **Temporary Life Insurance Agreement** – if applicable, to be left with the owner
- **ABR Disclosure** form – to be left with the owner
- **Notices** page – to be left with the proposed insured
- **Producer Report**

# Notes

- Be sure you have the most current version of the application
- Submit corresponding supplemental forms and questionnaires for applicable questions answered "Yes"
- Interstate Compact Product page (form # starting with **ICC**) is applicable for all Interstate Compact states. It lists all optional riders – to avoid selecting riders that are not approved in your state, be sure to check the Product State Availability and Variations list on the producer website
- Print legibly in ink
- Any corrections must be initialed by the owner, proposed insured and producer. Do not use white out
- 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)

# Product Details Page – Strong Foundation and Your Term

Do not submit this page to Foresters if Strong Foundation or Your Term is not applied for

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

### A Fraternal Benefit Society.

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

#### Proposed Insured

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

#### Foresters Term Life

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

Non-medical – Strong Foundation Term Life Term: <input type="radio"/> 10 year <input type="radio"/> 15 year <input type="radio"/> 20 year <input type="radio"/> 25 year <input type="radio"/> 30 year	Medical – Your Term Life Term: <input type="radio"/> 10 year <input type="radio"/> 15 year <input type="radio"/> 20 year <input type="radio"/> 25 year <input type="radio"/> 30 year
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#### 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 only): \$ \_\_\_\_\_  
 OR  
 Disability Income (accident and sickness): (Available only on Your Term) \$ \_\_\_\_\_  
 If Disability Income (accident and sickness) applied for but not approved, applying for Disability Income (accident only)?  Yes  No

<input type="radio"/> Accidental death: \$ _____	<input type="radio"/> Children's term: \$ _____	<input type="radio"/> Waiver of premium
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Other rider(s): \_\_\_\_\_

#### Remarks:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If applying for this rider, make sure the questions in the Children's Term Rider section is answered

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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## Proposed Insured:

- Ensure the name matches the proposed insured's name entered on page 1 of the Application for Individual Life Insurance

## Product Details:

- Fill in the amount and select one term
- Select either Strong Foundation for Non-medical or Your Term for Medical Underwriting (some issue ages have face amount ranges where both underwriting types are available, it is important to indicate which type is being applied for)
- Include details about the beneficiary for the Charity Benefit Provision

## Rider Details:

- Select the desired rider(s) – the appropriate circle must be filled in along with an amount (if applicable)
- Either the Disability Income Rider (Accident Only) or Disability Income Rider (Accident & Sickness) can be selected, **not both**. Disability Income Rider (Accident & Sickness) is only available on Your Term

# Product Details Page – SMART UL

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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**

(Each field in this section must be completed.)

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?  Yes  No

If "Yes", indicate the anticipated amount of 1035 exchange funds, if any, and the amount and source of any non-1035 exchange funds.

1035 exchange funds \$ \_\_\_\_\_

Non-1035 exchange funds \$ \_\_\_\_\_

Source of non-1035 exchange funds: \_\_\_\_\_

**Charity 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:

Guaranteed purchase option

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

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

Waiver of monthly deductions

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 before the certificate can be issued. Check the State requirements.

This form is part of the Application

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 ICC18 770624 US 04/18

**If applying for this rider, make sure the questions in the Children's Term Rider section is answered**

## Proposed Insured:

- Ensure the name matches the proposed insured's name entered on page 1 of the Application for Individual Life Insurance

## Product Details:

- Fill in the amount of life insurance
- Select either Non-medical or Medical Underwriting (some issue ages have face amount ranges where both underwriting types are available, it is important to indicate which type is being applied for)
- A Death Benefit Option (Level or Increasing) and a Life Insurance Qualification Test (GPT or CVAT) must be selected
- Submit a signed illustration or Illustration Certification at time of application to avoid delays
- Include details about the beneficiary for the Charity Benefit Provision


## Rider Details:

- If riders are selected, the appropriate circle must be filled in along with an amount (if applicable)

# Product Details Page – Advantage Plus Whole Life

Do not submit this page to Foresters if Advantage Plus Whole Life is not applied for

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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.)**

<input type="radio"/> Accidental death: \$ _____	<input type="radio"/> Children's term: \$ _____	<input type="radio"/> Disability income (accident only): \$ _____
<input type="radio"/> Guaranteed insurability \$ _____	Term: <input type="radio"/> 10 year <input type="radio"/> 20 year	<input type="radio"/> Waiver of premium
<input type="radio"/> Flexible payment paid-up additions Maximum annual payment amount: \$ _____ Planned payment amount (by mode): \$ _____ <small>(must be the same mode as premiums for certificate)</small>	<input type="radio"/> Single payment paid-up additions Planned payment amount: \$ _____	
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.		
Payment method: <input type="radio"/> Check <input type="radio"/> PAC (planned payment amount will be added to the amount to be drafted as first premium payment).		
Source of payment: _____		
<input type="radio"/> Transfer <input type="radio"/> Other		

**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 is issued.

This form is part of the Application for Insurance.

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 ICC17 770684 US 05/17

**If applying for this rider, make sure the questions in the Children's Term Rider section is answered**

## Proposed Insured:

- Ensure the name matches the proposed insured's name entered on page 1 of the Application for Individual Life Insurance

## Product Details:

- Fill in the amount of life insurance
- A plan type must be selected
- Select either Non-medical or Medical Underwriting (some issue ages have face amount ranges where both underwriting types are available, it is important to indicate which type is being applied for)
- A Death Benefit Option (Level or Increasing) and a Life Insurance Qualification Test (GPT or CVAT) must be selected (see product guide for more information)
- Submit a signed illustration or Illustration Certification at time of application to avoid delays
- A Dividend Option must be selected
- Answer "Yes" or "No" for automatic premium loan provision
- Include details about the beneficiary for the Charity Benefit Provision

## Rider Details:

- If riders are selected, the appropriate circle must be filled in along with an amount (if applicable)

# Product Details Page – Advantage Plus Whole Life

## Details on the Paid-Up Addition and Term Riders

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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.

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

<input type="radio"/> Accidental death: \$ _____	<input type="radio"/> Children's term: \$ _____	<input type="radio"/> Disability income (accident only): \$ _____
<input type="radio"/> Guaranteed insurability	Term: <input type="radio"/> 10 year <input type="radio"/> 20 year \$ _____	<input type="radio"/> Waiver of premium

<input type="radio"/> 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.	<input type="radio"/> Single payment paid-up additions Planned payment amount: \$ _____ Payment method: <input type="radio"/> Check <input type="radio"/> PAC (planned payment amount will be added to the amount to be drafted as first premium payment). <input type="radio"/> Transfer <input type="radio"/> Other _____ Source of payment: _____
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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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### Term Rider:

- Client can choose either a 10 year term or 20 year term, but not both

### PUA Rider:

- Client can choose Flexible payment paid-up additions (PUA) or Single payment paid-up additions, or both
- Flexible payment paid-up additions (available on medical underwriting basis only):
  - Enter the annual PUA amount applied for in **the Maximum annual payment** amount field (subject to underwriting and the maximum annual amount in effect at the time of application). Note that the amount input in this field will be multiplied by the appropriate underwriting factor and then added to the base certificate coverage amount and the Term rider amount (if applicable), to determine underwriting requirements
  - Enter the desired payment amount in the **Planned payment amount** field:
    - Client can choose any amount as long as it meets our modal minimum payment amounts (mode must match that chosen for the certificate premiums) of \$50 monthly, \$150 quarterly, \$300 semi-annually or \$600 annually and doesn't exceed the maximum annual payment amount entered above.
    - Enter \$0.00 if the client does not want to begin making a PUA rider payment at this time



# Product Details Page – Advantage Plus Whole Life

## Details on the Paid-Up Addition (cont.)

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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.

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

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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## PUA Rider (cont.)

- Single payment paid-up additions (available on both Non-medical and Medical underwriting basis):
  - Enter the desired lump sum amount in the **Planned payment amount** field. Note that the amount input in this field will be multiplied by the appropriate UW factor and then added to the base certificate coverage amount and the Term rider amount (if applicable) to determine underwriting requirements
  - If **PAC** is selected, the amount input in this field will be added to the premiums for the base certificate and riders as the total PAC withdrawal for the first premium payment
  - If **Transfer** is selected, be sure to enter the source of payment (e.g. 1035 exchange, and submit a completed 1035 exchange form(s) with the application)
  - If applying for non-medical underwriting basis, the source of payment must be 1035 exchange. No other form of payment is allowed

# Application for Individual Life Insurance – General Information

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**Application for Individual Life Insurance**

<b>Proposed Insured</b>					
First name	Middle name	Last name	<input type="radio"/> Male <input type="radio"/> Female		
Street address		City	State	Zip	
Social security #	Home phone #	Alternate phone/Cell #	Date of birth (mm/dd/yyyy)	State & Country of birth	
U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No. If "No", immigration status: <input type="radio"/> Green card holder <input type="radio"/> Permanent resident <input type="radio"/> Other (provide Visa type): _____					
Type of Photo I.D.: <input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government I.D.: _____					
Photo I.D. # (used to verify identity): _____					
Occupation & duties: _____					
<input type="radio"/> Full time	<input type="radio"/> Part time	<input type="radio"/> Seasonal	Income (past 12 m	<div style="border: 1px solid black; padding: 5px; display: inline-block;">           If Driver's license, make sure you specify the state         </div>	
Foresters member?		Email			
<input type="radio"/> Yes <input type="radio"/> No, applying for membership. _____ <input type="radio"/> English <input type="radio"/> Spanish					
<b>Owner</b> (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.: <input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> 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:	<input type="radio"/> Male <input type="radio"/> Female	Date of birth (mm/dd/yyyy)	U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No. If "No", immigration status: <input type="radio"/> Green card holder <input type="radio"/> Permanent resident <input type="radio"/> Other (provide Visa type): _____		
<b>Beneficiary</b> (Each beneficiary below is revocable, unless "irrevocable" is written next to the name of that beneficiary.)					
		Date of birth (mm/dd/yyyy)	Relationship to proposed insured	% Share	
<b>Primary</b>					
Name:				Total	
Address:				most equal	
Name:				100%	
Address:					
<b>Contingent</b>					
Name:				Total must	
Address:				equal	
Name:				100%	
Address:					
<b>Financial Questions</b>					
1. Is there an understanding or agreement, whether in writing or not, or has an offer been made to:					<input type="radio"/> Yes <input type="radio"/> No
a) Borrow or be given money, or other property, to pay for or enter into the insurance contract applied for?					<input type="radio"/> Yes <input type="radio"/> No
b) Sell, transfer or assign an insurance contract issued as a result of this Application?					<input type="radio"/> Yes <input type="radio"/> No
If "Yes" to 1a or 1b, provide details: _____					

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- Record the responses to each question

## Owner

- The owner can be the proposed insured or a 3<sup>rd</sup> party (e.g. business, trust or individual) where insurable interest requirements are met
- Fill out the owner information only if the proposed insured is not the owner
- If a contingent owner is to be named, submit the Contingent Owner/Other Payer Identification Form

## Beneficiary

- Each beneficiary designation must include the beneficiary's relationship to the proposed insured and the % and share. % shares MUST be in whole numbers (no fractions) and MUST total 100% for Primary and 100% for Contingent if beneficiaries designated

## Financial Questions

- Provide details to a "Yes" answer in the designated area. If more space is needed, go to the Additional Information section or attach additional paperwork

# Application for Individual Life Insurance – Lifestyle and Medical Questions

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: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No
10. Are you currently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> 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)?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

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- Ask each question exactly as worded and record each answer as given by the proposed insured (even if you know or suspect that a given answer is incorrect. If this happens, alert the underwriter on the Producer Report or a cover letter)
- Answer all questions of the Lifestyle and Part 1 of the Medical Question sections for all products
- We require additional information for each "Yes" answer. You can provide details in the Additional Information section or complete the corresponding questionnaire.

## Lifestyle Questions

- Indicate tobacco/nicotine use - Smoking status is based on the date that the proposed insured last used cigarettes, marijuana or other tobacco or nicotine products

## Part 1: Medical Questions

- Recording an accurate and complete health history is important for expediting the underwriting process. Partial or vague declarations often raise more questions which may cause delays in processing the application.

# Application for Individual Life Insurance – Additional Medical Questions & Riders Questions

We require additional information for each “Yes” answer. You can provide details in the Additional Information section or complete the corresponding questionnaire.

## Part 2: Additional Medical Questions

- Complete this section **only if** applying for a medically underwritten product
- Recording an accurate and complete health history is important for expediting the underwriting process. Partial or vague declarations often raise more questions which may cause delays in processing the application
- While completing an application for a Foresters non-medical product and you suspect that your client may be declined, complete Part 2 of the Additional Medical Questions section as part of the non-med application
- If the non-med application is declined they can apply for a Foresters medically underwritten product in one of two ways:
  - If Part 2: Additional Medical Questions were not completed, complete a new application with all required signatures, and send back to Foresters; or
  - Submit a cover letter with the statement “Non-med decline (certificate #) – please process as medically underwritten” along with an updated Product Details Page and the answers to Part 2: Additional Medical Questions section if not previously submitted.

## Disability Income/Waiver Rider Questions

- Complete **only if** applying for Disability Income and/or Waiver coverage

## Children’s Term Rider Questions

- Complete **only if** applying for Children’s Term Rider

Note: If you opted for either of these riders on the Product details page, make sure the relevant rider questions are answered to avoid delays

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? If “Yes”, specify: Type used: _____ Date last used: _____ If currently smoking, how many pack(s) per day? _____					<input type="radio"/> Yes <input type="radio"/> No
17. Do you currently drink alcohol? If “Yes”, specify: How many times per week? ____ How many drinks per occasion? ____					<input type="radio"/> Yes <input type="radio"/> 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?					<input type="radio"/> Yes <input type="radio"/> 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?					<input type="radio"/> Yes <input type="radio"/> No
20. Net worth: \$ _____					
21. Primary Physician Name (if different from question 9): _____ Phone #: _____ Address: _____					
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?					<input type="radio"/> Yes <input type="radio"/> 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?					<input type="radio"/> Yes <input type="radio"/> 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?					<input type="radio"/> Yes <input type="radio"/> 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 (mm/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? 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? If “Yes”, to either question 26a or 26b, complete the chart below.					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
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.					

# Application for Individual Life Insurance – Additional Information

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? If "Yes", specify: Type used: _____ Date last used: _____ If currently smoking, how many pack(s) per day? _____			<input type="radio"/> Yes <input type="radio"/> No
17. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____			<input type="radio"/> Yes <input type="radio"/> 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?			<input type="radio"/> Yes <input type="radio"/> 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?			<input type="radio"/> Yes <input type="radio"/> 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?			<input type="radio"/> Yes <input type="radio"/> 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?			<input type="radio"/> Yes <input type="radio"/> 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?			<input type="radio"/> Yes <input type="radio"/> 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	Date of birth	Height Weight Amount of coverage
26. Within the past 5 years, has a child listed above: a) Been diagnosed with, received treatment or medication for a disease or disorder of the back, neck or musculoskeletal system? 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? If "Yes", to either question 26a or 26b, complete the chart below.			<input type="radio"/> Yes <input type="radio"/> No
Question #	Name of child	Diagnosis, date(s), treatment, present condition	Physician's name, address and phone #
<b>Additional Information (Explain all "Yes" answers where applicable.)</b> Include Question #, diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone #s.			

If applying for Children's Term Rider, make sure you select the rider on the Product Details page

## Additional Information & Questionnaires

Additional information is required for each "Yes" answer in the Lifestyle, Medical, and Rider Questions sections. You can help speed up the Underwriting process by completing, at the time of the application, the **Underwriting Questionnaire** that is applicable to each "Yes" answer. The following questionnaires are the most common and should cover most of your cases:

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

For all other "Yes" answers, please include the following details in the Additional Information section of the application:

Diagnosis	Treatment	Date first diagnosed
Prescribed medications and equipment	Medical facilities	Physicians' name, addresses and numbers
Dates of hospitalization, duration of each stay		

In the event insufficient or no details are provided in the application for a "Yes" answer or a discrepancy between information from MIB/Pharmacy checks and the application, Foresters will contact the producer for further information and may request to have a questionnaire completed.

All questionnaires can be found in the "Forms & Brochures" section of Foresters producer website under "Underwriting & Questionnaires". Consult the UW Guide for details.

# Application for Individual Life Insurance – Other Insurance & Payment Information and Authorization

## 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? If "Yes", provide date: \_\_\_\_\_ and reason: \_\_\_\_\_  Yes  No

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 1<sup>st</sup> and 28<sup>th</sup>) 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 #: \_\_\_\_\_

Ensure you make a selection for each item under the Payment Information and Authorization section

## 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.

## Other Insurance

- Indicate all annuities or insurance pending and in-force, including group insurance and whether it will be replaced
- Producers must comply with replacement laws and regulations and are expected to offer suitable products to their clients. You can refer to Foresters producer website ezbiz (Toolbox -> Toolkit) for details

## Payment Information and Authorization

- For 3<sup>rd</sup> party payer (not the proposed insured nor the owner), complete the Contingent Owner/Other Payer Identification form
- Payer's signature is required for PAC plans
- If PAC is selected, provide PAC banking information
- "Other" is to allow for methods other than PAC and Direct Bill which may become available in the future. Do NOT select at this point
- Preferred draft date: complete only if the client wants a future preferred draft date
- Conversion notification will allow Foresters to scan the check and submit to payer's bank electronically

# Application for Individual Life Insurance – TIA, Secondary Addressee & Declarations and Agreements

## 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	<input type="radio"/> Male <input type="radio"/> 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/We" 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.

## Temporary Life Insurance

- Answer all questions
- Temporary life insurance is provided up to \$500K if the following pre-conditions are met:
  - All TIA questions are answered 'No'
  - At least one monthly premium (via PAC or check), which includes the planned payment amount for the PUA rider if applied for, is given to the producer no later than the application date.
  - Total coverage applied for (excluding all riders) is less than or equal to \$1,000,000
  - Proposed insured older than 15 days old or younger than age 71
  - If PAC is selected, the first premium amount must equal the planned modal premium
- If TIA pre-conditions are not met: Check 'No' and obtain the owner's initials

## Secondary Addressee

- Complete **only if** designating another person to receive notification regarding a possible lapse

## Declarations and Agreements

- Proposed insured and owner (if other than the proposed insured) must review the declarations

# Application for Individual Life Insurance – Authorization, Signatures & Producer Certification

## 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 \_\_\_\_\_ on \_\_\_\_\_.

(State)

(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)

## Signatures

- Proposed insured and owner (if the proposed insured is not the owner), must review and sign this page
- For juvenile cases, parent/legal guardian signature is required if other than the owner

## Producer Certification

- Indicates that you certify the points in the Product Certification including that you are not aware of undisclosed information that might affect insurability, and that full and accurate information regarding the proposed insured and owner has been provided
- Ensure that all the questions are answered
- Use Producer Comments section on the Producer Report to provide details if required



# Temporary Life Insurance Agreement

## 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



### 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)?	<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 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,

*Anthony M. Garcia*

Anthony M. Garcia, President & Chief Executive Officer

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## Temporary Life Insurance Agreement (TIA)

- To be left with the owner if the pre-conditions are met.
- If pre-conditions not met:
  - Do not leave the TIA with the owner
  - On the TIA section of the application
    - Check "No" to the first acknowledgement question (below "Were all the pre-conditions to temporary coverage met?")
    - Obtain the owner's initials

# ABR Disclosure

## 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



### 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:

- 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
- 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 75<sup>th</sup> 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.

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- It's a regulatory requirement that an ABR disclosure must be given to all clients.
- ABR may not be available in all states

#### 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.

# Notices

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#### 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](http://www.mib.com).

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## Notices

- Provide to proposed insured for review
- Leave this page with the proposed insured
- This page:
  - Contains the notices legally required and Foresters contact information
  - Includes the privacy notice, underwriting process and Medical Information Bureau (MIB) information
  - Gives a description of some of the additional sources of underwriting information. The proposed insured consents to the release of this information to the MIB by signing the authorization to obtain and disclose information page. If the proposed insured requires further information about MIB or their record with them, they should contact MIB directly at the address provided on this page

# Producer Report

Producer Report		
<b>Proposed Insured</b>		
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.		<input type="radio"/> Yes <input type="radio"/> No
3. Is the proposed insured you, your spouse/partner or your child/stepchild?		<input type="radio"/> Yes <input type="radio"/> No
4. In the Application, are you the owner, payer or beneficiary?		<input type="radio"/> Yes <input type="radio"/> 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.		<input type="radio"/> Yes <input type="radio"/> No
6. Was a copy of the Buyer's Guide provided to the owner at the time of sale?		<input type="radio"/> Yes <input type="radio"/> 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)		
<b>Producer Comments</b> (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.)		

**For #1, please indicate the anticipated rating class for medically underwritten applications**

- Record the responses to each question
- Use the Producer Comments to provide general details of the application or regarding the Producer Certification statements
- The Vendor and Date Ordered fields are required on medically underwritten applications

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.

# Reminder

- Submit the corresponding underwriting questionnaire for applicable “Yes” answers to the lifestyle and medical questions. For other “Yes” answers, include complete details in the “Additional Information” section of the application
- To avoid having to obtain a signature(s) on delivery and a delay in getting paid ensure that all required sections of the application are completed properly
- To avoid selecting riders that are not approved in your state, be sure to check the Product State Availability and Variations list on the producer website for a list of approved optional riders
- Provide all applicable replacement, rollover, surrender and disclosure forms

Visit Foresters producer ezbiz website  
Go to Forms and Brochures section for the  
application package, and supplemental  
forms for your state

Questions? Contact Sales Support at  
866 466 7166 (option 1)