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

Prepared Date: **6/3/2016 1:08 PM EST**

Document Name	Description	Expiration Date
105782_FL	Federal Employee and List Bill Overflow Form	12/31/2199
770484_FL_c	Application for Individual Life Insurance	12/31/2199
770781_FL_c	Application for Individual Life Insurance (Fe...	12/31/2199
101274-US	Illustration Certification	12/31/2199
100938US	Life Insurance Buyer's Guide	1/1/2199
105363_US	Addendum to Life Insurance Buyer’s Guide	12/31/2199
104989_FL	Important Notice: Replacement Of Life Insuran...	12/31/2199
105821_FL	Certificate Disclosure Replacement Form	12/31/2199
101252_FL	Notice and Consent for Blood or Urine Testing...	12/31/2199
105690_US_b	1035 Exchange Form	12/31/2199

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

Foresters

The Independent Order of Foresters ("Foresters")

Overflow Form

Overflow for the most recent application for individual life insurance.

Proposed Insured

First name:	Middle name:	Last name:	Date of birth (mmm/dd/yyyy):

Children's Questions Section Overflow

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

Overflow of chart to be completed for all "Yes" answers to questions in the Children's Questions section of the Application.
(Do not include information regarding treatment for HIV, AIDS or ARC.)

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

Additional Information Section Overflow (Do not include information regarding treatment for HIV, AIDS or ARC.)

Question #	Details

Other Insurance Section Overflow

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

Beneficiary Information Section Overflow

(Each beneficiary below is revocable. If, however, a beneficiary is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary. Total % Share between the Application and the Overflow Form must equal 100% for the named Primary Beneficiaries and 100% for the named Contingent Beneficiaries.)

Primary Beneficiary(ies)	Relationship to proposed insured	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Contingent Beneficiary(ies)	**Relationship to proposed insured**	**% Share**
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		

Questionnaire Overflow

Name of Questionnaire	Question #	Details

Signature Section – Overflow Form

"Application" means the application identified in this Overflow Form ("Form") on the life of the proposed insured.

I, the proposed insured, by signing this Form, declare that 1) I have provided the statements, answers, and representations shown in this Form as it applies to me and they are full, complete and true to the best of my knowledge and belief. 2) I understand and agree that: (a) this Form is part of and subject to the Application; and (b) the information provided in this Form will be relied upon as evidence of insurability that will influence the assessment and acceptance of the Application by Foresters.

Any person who knowingly and with intent to injure, defraud, or deceive, any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Proposed insured's signature: X _____ in (State) _____ on (mmm/dd/yyyy) _____

Agent/Producer's name (print full name): _____

Agent/Producer #: _____ Florida license identification#: _____

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

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Foresters

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 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 Toolbox/Underwriting Resources section of Foresters producer website before taking an application for Foresters products.

How to Avoid Delays and Get PAID Fast

- Money orders or cashier's checks are not permitted for the payment of initial premiums.
- 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. We may require additional information for each "Yes" answer in the Lifestyle and Medical Questions sections. You can help speed up the Underwriting process by completing the questionnaire that is applicable to each "Yes" answer or if an applicable questionnaire is not available by providing details in the Additional Information section.
- 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.
- Premium payments cannot be made by the producer (unless the proposed insured is the producer or a dependent of the producer).
- If submitting an application through the POS process, refer to the POS Reference Guide on Foresters producer website for instructions.

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

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

Questions? Go to Foresters producer website (foresters.com/Agent Login)

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Foresters

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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 ○ 25 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: $ _____	○ Waiver of premium

○ Other rider(s): _____

Remarks:

_____

_____

_____

_____

_____

_____

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

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

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

Proposed Insured

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

SMART Universal Life

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

Underwriting: ○ Non-medical ○ Medical

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

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

Riders (Subject to state and product availability.)

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

Complete if the proposed insured is a juvenile.

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

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

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

Remarks:

_____

_____

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

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

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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:
$ _____

○ 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.

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

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Application for Individual Life Insurance

Proposed Insured

First name:	Middle name:	Last name:	○ Male ○ Female

Street address (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? ○ Yes ○ No. If No, immigration status / type of Visa:_____	Primary language: ○ English ○ Spanish

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

Occupation & duties:	○ Full time ○ Part time ○ Seasonal
Hours worked per week (past 6 months): _____ Number of weeks worked in the past 12 months: _____	Income (past 12 months): $_____ Net worth: $ _____

Foresters member? ○ Yes ○ No, applying for membership.	Email address (optional):

Secondary Addressee (Optional. To designate another person to receive notification of a possible lapse in coverage.)

First name:	Middle name:	Last name:	○ Male ○ Female

Street address (cannot be a P.O. Box.):	City:	State:	Zip:

Owner (Complete only if other than the proposed insured. If not completed the proposed insured is the owner. 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:

○ Male ○ Female	Date of birth (mmm/dd/yyyy):	U.S. citizen? ○ Yes ○ No. If No, immigration status / type of Visa: _____

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.)

Primary Beneficiary(ies)

Name, date of birth, and address (street, city, state, zip code) of each primary beneficiary.	Relationship to proposed insured.	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		Total
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		must equal
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		100%

Contingent Beneficiary(ies)

Name, date of birth, and address (street, city, state, zip code) of each contingent beneficiary.	Relationship to proposed insured.	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		Total must
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		equal 100%

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, reduced or replaced, 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.

Children's Questions (Complete only if applying for Children's Term Coverage. For purposes of these questions, "diagnosed", "advised" and "treatment" mean by a licensed physician or medical practitioner.)

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? 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? If "Yes", to either question 5a or 5b, complete the chart below.	○ Yes ○ No ○ Yes ○ No

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

Financial Questions

6. Is there currently 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? b) Transferred, assigned, sold or pledged? If "Yes", to either question 6a or 6b provide details. _____	○ Yes ○ No ○ Yes ○ No
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.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the proposed insured.)

8. 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? _____	○ Yes ○ No
9. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____	○ Yes ○ No
10. Within the past 10 years have you: 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? 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?	○ Yes ○ No ○ Yes ○ No
11. Have you received notice of deployment or are you currently deployed, on active duty with the Military or the Reserves?	○ Yes ○ No
12. Have you, within the past 2 years, flown, or do you currently have plans to fly, in an aircraft as a student pilot, licensed pilot or crew member within the next 2 years?	○ Yes ○ No
13. Have you, within the past 2 years, engaged, or do you currently have plans to engage in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying within the next 2 years?	○ Yes ○ No
14. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____	○ Yes ○ No

15. Within the past 10 years have you:

a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: ○ Yes ○ No

Number of convictions: _____ State where each conviction occurred: _____

Date of most recent conviction:_____
(mmm/dd/yyyy)

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). _____ ○ Yes ○ No

_____

Medical Questions (For purposes of these questions "you" and "your" mean the proposed insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

16. a) Your: Height:_____ Weight:_____

b) Have you had a weight change of 10 pounds or more, within the past 12 months? If "Yes", specify: ○ Yes ○ No

○ Gain ○ Loss How many pounds? _____

Reason:_____

17. Date you last consulted a physician: _____

Physician Name:_____

Address:_____

a) Reason(s): _____

b) Were you advised that results of that consultation were within normal ranges? If "No", provide details. ○ Yes ○ No

_____

_____

18. Your Personal Physician(s), if different than question 17.

Name: _____ Address:_____ Phone #: _____

Name: _____ Address:_____ Phone #: _____

19. Within the past 5 years, have you consulted a physician other than identified in question 17 or 18, or a medical practitioner, or been a clinic, hospital or emergency room patient? ○ Yes ○ No

20. Are you presently taking prescription medication or under treatment? ○ Yes ○ No

21. Have you ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? ○ Yes ○ No

22. Do you, to the best of your knowledge and belief, 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, Alzheimer's, or other hereditary disorder? ○ Yes ○ No

Details to "Yes" answers to question 22.

	Age, if living	Age, at death	Details of condition / Cause of death
Father			
Mother			
Siblings			

23. 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

24. 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 organs?	○ 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. For purposes of this section, "diagnosed" and "treatment" mean by a licensed physician or medical practitioner.)

Question #	Include diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone numbers (if different than question 18). Do not include information regarding treatment for HIV, AIDS or ARC.

Payment Information and Authorization

The planned premium quoted may change following underwriting review.

Payer is:

O Proposed insured O Owner (if other than proposed insured) O Other (complete Contingent Owner/Other Payer Identification Form)

First premium payment to be made by:

O Pre-Authorized Check (PAC) O Check (payable to Foresters) O Other (complete Payment Form)

Subsequent premium payments to be made by:

O Pre-Authorized Check (PAC) O Direct Bill O Other (complete Payment Form)

Payment mode:

O Monthly (not available for direct bill) O Quarterly O Semi-annually O Annually

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

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

Type of account: O Checking O 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 (above) and is permitted to provide this authorization, and agrees that: 1) Foresters is authorized to draft deductions, under the PAC selections made in the Payment Information and Authorization section (above), 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 and each subsequent deduction, if any, will be made and the amount of each deduction according to the coverage(s) and certificate type 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 licensed physician or medical practitioner, for chest pain, heart problem, stroke, or cancer, or been diagnosed, by a licensed physician or medical practitioner, as having ARC or AIDS? ○ 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

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):

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

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, including each rider, applied for in this Application.

Declarations and Agreements

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

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true, to the best of my knowledge and belief.

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 insurance contract (defined as a certificate and each rider attached to that certificate) issued, if any, 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, subject to the Incontestability provision, 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 honored by 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, or 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 may review, transfer and otherwise use, information provided in this Application to offer and issue (including post issue administration), other insurance products to me. 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 agent/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) 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.

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 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 every child named, if any, and proposed for insurance, in this Application. "Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business 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. 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. 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.)

Any person who knowingly and with intent to injure, defraud, or deceive, any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

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

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

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

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

Agent/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 personally met with the proposed insured, owner and each child and reviewed the document(s) used to verify identity and birth date; c) 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; d) This Application was reviewed by each person signing in the Signature Section before it was signed by that person; e) 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; f) 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; g) 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; h) 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 life insurance or an annuity? ○ Yes ○ No

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

Agent/Producer's name (print full name): _____

Agent/Producer #: _____ Florida license identification #: _____

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

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789 Don Mills Road, Toronto, ON, Canada M3C 1T9
U.S. Mailing Address: P.O. Box 179, Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Foresters

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

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

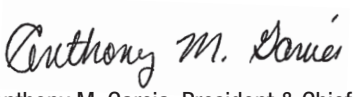
Termination of Temporary Coverage - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate 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 we offer, as shown in our 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 cancel or 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 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. Any person who knowingly and with intent to injure, defraud, or deceive, any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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, President & Chief Executive Officer

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Foresters

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Accelerated Death Benefit Rider Disclosure

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

Benefit Description

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

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

Chronic illness means the insured:

a) Is unable to perform, without substantial assistance from another person, at least two of the activities of daily living (bathing, continence, dressing, eating, toileting or transferring) for a period of at least 90 days, due to a loss of functional capacity; or
b) Requires substantial supervision by another person to protect the insured from threats to health and safety due to the insured's severe cognitive impairment.

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

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

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

Amount of the Accelerated Death Benefit Payment

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

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

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

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

Effect of Payment on the Certificate

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

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

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

Effect of Payment on Taxation and Eligibility for Public Assistance

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

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

I acknowledge that I have been provided with this disclosure for review.

Prospective Owner's Name (print full name): _____

Prospective Owner's Signature: X _____ Date (mmm/dd/yyyy):_____

I understand that two copies of this disclosure should be completed and signed. I certify that one copy will be left with the prospective owner and one copy will be returned to Foresters.

Producer's Name (print full name): _____

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

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I acknowledge that I have been provided with this disclosure for review.

Prospective Owner's Name (print full name): _____

Prospective Owner's Signature: X _____ Date (mmm/dd/yyyy):_____

I understand that two copies of this disclosure should be completed and signed. I certify that one copy will be left with the prospective owner and one copy will be returned to Foresters.

Producer's Name (print full name): _____

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

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Foresters

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 and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business operations; "Producer" means the licensed individual who signed the Application as the producer; "You" and "Your" mean individually the proposed insured, and each child, if any, identified in the Application. If you have questions regarding your application, discuss them with your producer or contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. Box 179, Buffalo, NY 14201-0179.

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

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, we may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character and general reputation. They may also include personal characteristics, such as health, prescription history, finances, job and mode of living. The federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from Foresters about the nature and scope of an investigation. We will provide the contact information of any agency we ask to prepare such a report. You may contact the agency to learn about the contents or request a copy of the report. You may request a personal interview with the agency and they will make a reasonable attempt to talk to you. It will include that information in its report. If we order a report, it may include information obtained through interviews with your neighbors, friends or others you know. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for AIDS information.

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

Producer Report

Proposed Insured

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

Producer's name	Producer #	% of split
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. 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.

3. Are you related to the proposed insured? If "Yes", please state the relationship in the Producer Comments section below.	○ Yes ○ No
4. 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 Producer Comments section below.	○ Yes ○ No
5. Was a copy of the Buyer's Guide provided to the owner at the time of sale?	○ Yes ○ No

6. If a personal health interview (PHI) was conducted as part of the application process, provide the PHI Inspection Reference ID #.

   _____

7. 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)		

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

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

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

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

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U.S. Mailing Address: P.O. Box 179, Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Foresters

The Independent Order of Foresters ("Foresters")

Tips for Submitting a Foresters Application for Individual Life Insurance (Federal Employee or List Bill only)

Foresters Fraternal Difference

- Foresters shares its financial strength with its members by offering them more than just a financial product; eligible members may also benefit from 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 help 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 Toolbox/Underwriting Resources section of Foresters producer website before taking an application for Foresters products.

How to Avoid Delays and Get PAID Fast

- Money orders or cashier's checks are not permitted for the payment of initial premiums.
- 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. We may require additional information for each "Yes" answer in the Questions section. You can help speed up the Underwriting process by completing the questionnaire that is applicable to each "Yes" answer or if an applicable questionnaire is not available by providing details in the Additional Information section.
- Where additional space is required, use an Overflow Form.
- Complete and send required forms (e.g. payroll authorization) as instructed by the individual Federal Employee or List Bill service provider.
- Ensure that the life insurance preferred issue date is aligned with the individual Federal Employee or List Bill service provider's rules.

Checklist

Proposed Insured	Producer
✓Initialed all corrections (do not use white out), if any & signed the Signature section ✓Initialed the TIA Acknowledgement (if pre-conditions not met) ✓Signed & dated the Overflow Form (if required)	✓Initialed all corrections, if any, & signed the Producer Certification section ✓Signed & dated the Overflow Form (if required)
Send to Foresters	**Leave with Proposed Insured/Owner**
✓Completed application, the Product Details page and the Producer Report section If applicable: ✓ Underwriting questionnaire(s) ✓ State and Foresters replacement/rollover/surrender/disclosure form ✓ Notice of Consent for Blood and Body Fluid Testing ✓ Signed Illustration or illustration acknowledgement/certification form ✓ Overflow Form	✓ TIA Agreement (if pre-conditions are met) ✓ Disclosure forms (if required) ✓ Buyer's Guide ✓Notices

Questions? Go to Foresters producer website (foresters.com/Agent Login)

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Foresters

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 ○ 25 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: $ _____	○ Waiver of premium

○ Other rider(s): _____

Remarks:

_____

_____

_____

_____

_____

_____

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

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

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Foresters

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: $ _____

Underwriting: ○ Non-medical ○ Medical

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

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

Riders (Subject to state and product availability.)

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

Complete if the proposed insured is a juvenile.

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

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

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

Remarks:

_____

_____

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

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

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Foresters

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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:
$ _____

○ 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.

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

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Foresters

The Independent Order of Foresters ("Foresters")

Application for Individual Life Insurance (Federal Employee or List Bill Only)

O Federal Employee O List Bill (Complete Payroll Authorization Form) Employer Name: _____

TPA Service Provider: _____ Proposed Issue Date (mmm/dd):_____

Monthly Premium Quoted (Premium quoted may change following underwriting review): $_____ (Payer is the proposed insured.)

Proposed Insured (The proposed insured is to be the owner. If the proposed insured is not to be the owner use Foresters standard application.)

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

Secondary Addressee (Optional. To designate another person to receive notification of a possible lapse in coverage.)

First name:	Middle name:	Last name:		O Male O Female
Street address (cannot be a P.O. Box.):		City:	State:	Zip:

For each "Yes" answer in the Questions section 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.

Questions (For purposes of these questions "you" and "your" mean the proposed insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

1. Is there currently 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? b) Transferred, assigned, sold or pledged?	 O Yes O No O Yes O No
2. Has the proposed insured or a beneficiary arranged, been offered, or received, an inducement, fee or compensation to buy, or pay for, the insurance applied for?	O Yes O No
3. 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? _____	O Yes O No
4. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____	O Yes O No
5. Within the past 10 years have you: 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? 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?	 O Yes O No O Yes O No
6. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or Reserves?	O Yes O No
7. Have you, within the past 2 years, flown, or do you currently have plans to fly in an aircraft as a student pilot, licensed pilot or crew member within the next 2 years?	O Yes O No
8. Have you, within the past 2 years, engaged, or do you currently have plans to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying within the next 2 years?	O Yes O No
9. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and the State where each occurred. _____ _____	O Yes O No

10. Within the past 10 years have you: a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: Number of convictions:_____ State where each conviction occurred:_____ Date of most recent conviction:_____ 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). _____	O Yes O No O Yes O No
11. a) Your: Height: _____ Weight: _____ b) Have you had a weight change of 10 pounds or more, within the past 12 months? If "Yes", specify: O Gain O Loss How many pounds? _____ Reason: _____	O Yes O No
12. Date you last consulted a physician: _____ Physician Name: _____ Address: _____ a) Reason(s):_____ b) Were you advised that results of that consultation were within normal ranges? If "No," provide details. _____ _____	O Yes O No

13. Your Personal Physician, if different than question 12.
Name: _____ Address: _____ Phone #: _____

14. Within the past 5 years, have you consulted a physician other than identified in question 12 or 13, or a medical practitioner, or been a clinic, hospital or emergency room patient?	O Yes O No
15. Are you presently taking prescription medication or under treatment?	O Yes O No
16. Have you ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?	O Yes O No
17. Do you, to the best of your knowledge and belief, 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, Alzheimer's, or other hereditary disorder? If "Yes", complete the chart below. If more space is required, use the Additional Information section.	O Yes O No

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

18. 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? 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? c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?	O Yes O No O Yes O No O Yes O 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: 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? b) Anemia, high cholesterol, swollen glands or a disease or disorder of the blood or lymphatic system? c) Cancer, tumor, polyp, cyst, melanoma, unexplained swelling or lump or a malignancy? d) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, chronic cough, sleep apnea, or a disease or disorder of the respiratory system? e) Seizures, epilepsy, dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, or a disease or disorder of the brain or nervous system? f) Anxiety, depression, bi-polar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder (PTSD) or a mental health disorder? g) Blood or albumin in the urine or a disease or disorder of the prostate, bladder, kidney or genito-urinary organs? h) Diabetes, or a disease or disorder of the thyroid, pituitary, pancreas or endocrine system? i) Hepatitis, colitis, ileitis, gastritis, ulcer, Crohn's disease or a disease or disorder of the digestive system? j) Arthritis, fibromyalgia, or a disease or disorder of the back, neck or musculoskeletal system? k) Lupus or a disease or disorder of the immune system (other than HIV) or connective tissue?	O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No

Children's Questions (Complete only if applying for Children's Term Coverage. For purposes of these questions, "diagnosed", "advised" and "treatment" mean by a licensed physician or medical practitioner. To list additional children, use an Overflow Form.)

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

20. Has a child listed above: a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease? 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? If "Yes", to either question 20a or 20b, complete the chart below (for additional space, use an Overflow Form).	O Yes O No O Yes O No

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

Additional Information (Explain all "Yes" answers from the Questions section. For additional space, use an Overflow Form. For purposes of this section, "diagnosed" and "treatment" mean by a licensed physician or medical practitioner.)

Question #	Include diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone numbers (if different than question 13). Do not include information regarding treatment for HIV, AIDS or ARC.

Other Insurance

21. Is there another annuity or life insurance application pending for the proposed insured with Foresters or another insurer? 22. Does the proposed insured currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force? If "Yes", to question 21 or 22, complete the chart below. Also include details about Foresters life insurance or annuity certificate(s) (for additional space, use an Overflow Form).	O Yes O No O Yes O No

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

23. 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 _____	O Yes O No
24. Will coverage be discontinued, reduced or replaced, 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)?	O Yes O 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.

Declarations and Agreements

"Application" means this Application for Individual Life Insurance and includes additional forms, if any, that are part of this Application. "I/Me" means the person identified in this Application as the proposed insured.

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.

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 insurance contract (defined as a certificate and each rider attached to that certificate) issued, if any, 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, subject to the Incontestability provision, 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 or authorized on or before the delivery date of that insurance contract and is received by Foresters from the account 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, or 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 may review, transfer and otherwise use, information provided in this Application to offer and issue (including post issue administration), other insurance products to me. 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 me 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 agent/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) 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.

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.)

Primary Beneficiary(ies)		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	Relationship	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	to	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	proposed	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	insured	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:		% Share
Contingent Beneficiary(ies)		
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	Relationship	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	to	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	proposed	% Share
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address:	insured	% Share

Temporary Life Insurance Agreement (TIA) Questions

Has the proposed insured:

1. Within the past 24 months, had either an investigation or treatment, by a licensed physician or medical practitioner, for chest pain, heart problem, stroke, or cancer, or been diagnosed, by a licensed physician or medical practitioner, as having ARC or AIDS? O Yes O 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)? O Yes O 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? O Yes O No

TIA Acknowledgement: Will the TIA be left with the proposed insured?

O No. The proposed insured acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided or authorized. X _____ (Proposed insured's initials)

O Yes. Complete the TIA and leave it with the proposed insured. First premium payment, in the amount of $ _____, is provided or authorized.

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, including each rider, applied for in this Application.

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 operations and (d) record keeping and future servicing by authorized persons. In this authorization, "proposed insured" means the person identified as such in this Application. "Child" means every child named, if any, and proposed for insurance, in this Application. "Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business operations. As evidenced by the signature in the Signature Section of this Application, the proposed insured, on their behalf and on behalf of each child, 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, on their behalf and on behalf of each child, 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. A copy of this authorization shall be as valid as the original. The proposed insured 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. 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.)

Any person who knowingly and with intent to injure, defraud, or deceive, any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Proposed insured's signature: X _____ in (State) _____ on (mmm/dd/yyyy) _____.

Agent/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 personally met with the proposed insured and each child and reviewed the document(s) used to verify identity and birth date; c) I asked the proposed insured each question as written in this Application to which an answer is shown, and recorded the answers as given to me; d) This Application was reviewed by the proposed insured before it was signed; e) This Application has not been altered in any way after the proposed insured signed it; f) 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; g) 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; h) 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 life insurance or an annuity? O Yes O No
Are you related to the proposed insured? O Yes O No

Agent/Producer's name (print full name): _____

Agent/Producer #: _____ Florida license identification#: _____

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

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Foresters

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

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

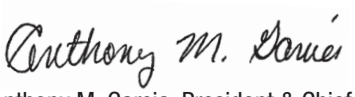
Termination of Temporary Coverage - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate 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 we offer, as shown in our 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 cancel or 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 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. Any person who knowingly and with intent to injure, defraud, or deceive, any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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, President & Chief Executive Officer

The Independent Order of Foresters ("Foresters") - A Fraternal Benefit Society.
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Foresters

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Accelerated Death Benefit Rider Disclosure

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

Benefit Description

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

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

Chronic illness means the insured:

a) Is unable to perform, without substantial assistance from another person, at least two of the activities of daily living (bathing, continence, dressing, eating, toileting or transferring) for a period of at least 90 days, due to a loss of functional capacity; or
b) Requires substantial supervision by another person to protect the insured from threats to health and safety due to the insured's severe cognitive impairment.

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

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

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

Amount of the Accelerated Death Benefit Payment

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

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

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

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

Effect of Payment on the Certificate

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

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

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

Effect of Payment on Taxation and Eligibility for Public Assistance

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

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

I acknowledge that I have been provided with this disclosure for review.

Prospective Owner's Name (print full name): _____

Prospective Owner's Signature: X _____ Date (mmm/dd/yyyy):_____

I understand that two copies of this disclosure should be completed and signed. I certify that one copy will be left with the prospective owner and one copy will be returned to Foresters.

Producer's Name (print full name): _____

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

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I acknowledge that I have been provided with this disclosure for review.

Prospective Owner's Name (print full name): _____

Prospective Owner's Signature: X _____ Date (mmm/dd/yyyy):_____

I understand that two copies of this disclosure should be completed and signed. I certify that one copy will be left with the prospective owner and one copy will be returned to Foresters.

Producer's Name (print full name): _____

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

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Foresters

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 and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business operations; "Producer" means the licensed individual who signed the Application as the producer; "You" and "Your" mean individually the proposed insured, and each child, if any, identified in the Application. If you have questions regarding your application, discuss them with your producer or contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. Box 179, Buffalo, NY 14201-0179.

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

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, we may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character and general reputation. They may also include personal characteristics, such as health, prescription history, finances, job and mode of living. The federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from Foresters about the nature and scope of an investigation. We will provide the contact information of any agency we ask to prepare such a report. You may contact the agency to learn about the contents or request a copy of the report. You may request a personal interview with the agency and they will make a reasonable attempt to talk to you. It will include that information in its report. If we order a report, it may include information obtained through interviews with your neighbors, friends or others you know. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for AIDS information.

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

Producer Report

Proposed Insured

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

Producer's name	Producer #	% of split
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. If maintaining the face amount would cause the premium to fall below our minimum premium guidelines the certificate will be issued to maintain premium and in certain instances additional medical requirements will be requested. If the premium quoted changes, the payroll deduction form from the appropriate TPA service provider will need to be completed and re-adjusted to reflect the adjusted premium amount.

2. Are you related to the proposed insured? If "Yes", please state the relationship in the Producer Comments section below.	O Yes O No
3. Have you submitted an additional application to Foresters: a) On the proposed insured? b) On a family member of the proposed insured? If "Yes", list the name(s) in the Producer Comments section below.	 O Yes O No O Yes O No
4. Was a copy of the Buyer's Guide provided to the proposed insured at the time of sale?	O Yes O No

5. If a personal health interview (PHI) was conducted as part of the application process, provide the PHI Inspection Reference ID #. _____

6. 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)		

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

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

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

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

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Illustration Certification

This certification is to be used if an illustration conforming to the insurance product as applied for in the application was NOT provided to the prospective owner at the time of application. If an illustration conforming to the insurance product as applied for in the application was provided to the prospective owner, a signed copy of that illustration must be submitted with the application and this form should not be completed.

Proposed Insured's Name: _____ **Plan Applied For**: _____

Prospective Owner's Name: _____ **Producer's Name**: _____
(if other than proposed insured)

Producer's Certification *(Check the one box that applies.)*

☐ No illustration was used in the sale of the insurance product applied for in the application and no illustration was provided to the prospective owner. An illustration conforming to the insurance contract issued, if any, will be provided to the owner no later than at the time of delivery of the insurance contract.

☐ An illustration that does not conform to the insurance product applied for in the application was used in the sale of that insurance product. An illustration conforming to the insurance contract issued, if any, will be provided to the owner no later than at the time of delivery of the insurance contract.

☐ A computer screen illustration, which complies with state requirements, was displayed to the prospective owner in the sale of the insurance product applied for in the application. The illustration was based upon the following information:

Plan Applied For:		**Face Amount: $**
Premium Amount: $	**Premium Mode:** **O** Monthly **O** Quarterly **O** Semi-annually **O** Annually	
Sex: **O** Male **O** Female	**Issue Age:**	**Insurance Class:** **O** Tobacco **O** Non-Tobacco
Dividend Option: **O** Paid-up additions **O** Paid in cash **O** Left on deposit **O** To reduce premiums		
Rider(s) (name and benefit amount):		

Universal Life Only

Death Benefit: **O** Level **O** Increasing	**Guaranteed Interest Rate:** %	**Current Interest Rate** (Non-Guaranteed)**:** %
Life Insurance Qualification Test: **O** Guideline Premium Test (GPT) **O** Cash Value Accumulation Test (CVAT)		

A copy of the computer screen illustration was NOT provided to the prospective owner. An illustration conforming to the insurance contract issued, if any, will be provided to the owner no later than at the time of delivery of the insurance contract.

_____ _____
Producer's Signature Date (mmm/dd/yyyy)

Prospective Owner's Certification

I acknowledge that I have not been provided with a copy of an illustration conforming to the insurance product applied for in the application. I understand that an illustration conforming to the insurance contract, if any, issued as a result of the application will be provided to me no later than at the time of delivery of the insurance contract.

_____ _____
Prospective Owner's Signature Date (mmm/dd/yyyy)

Two copies of this form should be completed and signed. One copy should be left with the prospective owner and one copy returned to Foresters.

101274 US 05/11

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Prospective Owner's Name: _____ **Producer's Name**: _____
(if other than proposed insured)

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Dividend Option: **O** Paid-up additions **O** Paid in cash **O** Left on deposit **O** To reduce premiums		
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Foresters

Life Insurance Buyer's Guide

This guide must be used in the following states:

AK, AL, AR, CA, CO, DC, HI, ID, KS, LA, MA, MD, ME*, MI, MN, MS, NE, NM, OK, PA, RI, SC, TX, UT, VA, WI, WV & WY

Note:

- The following states require Addendum 105363 US is included with this guide:

  DE, FL, IA, NC, ND, NV, NY, OH, SD & WA

- * ME requires guide 100938 US for illustrated products and 105361 ME for non-illustrated products

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy that meets your needs and fits your budget
- Decide how much insurance you need
- Make informed decisions when you buy a policy

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?

3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.

5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.

6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.

7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

BUYING LIFE INSURANCE

When you buy life insurance, you want a policy which fits your needs.

First, decide how much you need – and for how long – and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance also can be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?

- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up **cash values** and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash values.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period – even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more

premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole life insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider.
For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies – those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are non-guaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Foresters

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This Addendum must be used in the following states
and included with Life Insurance Buyer's Guide 100938 US:

DE, FL, IA, NC, ND, NV, NY, OH, SD & WA

ADDENDUM TO LIFE INSURANCE BUYER'S GUIDE

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "nonparticipating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash Values
3. Dividends

Cost Indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is no enough to just add

up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract and multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies.

1. LIFE INSURANCE SURRENDER COST INDEX - This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

2. LIFE INSURANCE NET PAYMENT COST INDEX - This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non-participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non-participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a Shopper's Guide tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.

(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

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IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

A decision to buy a new policy or contract and discontinue or change an existing policy or contract may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed and your existing policy(ies) or contract(s). New policies or contracts may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy(ies) or contract(s).

Your best source for facts on the proposed policy or contract is the proposed company and its producer. The best source on your existing policy or contract is the existing company and its producer.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy or contract, Florida regulations require notification of the company that issued the policy or contract.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy or contract values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer(s) by placing your initials in the appropriate box below.

☐ YES ☐ NO

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY OR CONTRACT UNTIL YOUR NEW POLICY OR CONTRACT HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
APPLICANT'S SIGNATURE DATE

_____ _____
PRODUCER'S SIGNATURE DATE

_____ _____
PRODUCER'S NAME (PRINTED OR TYPED)

_____
PRODUCER'S ADDRESS (PRINTED OR TYPED)

_____
PRODUCER'S COMPANY (PRINTED OR TYPED)

Information on Policies or Contracts which may be replaced:

Company Name	Policy or Contract Number	Name of Insured

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APPLICANT'S SIGNATURE DATE

_____ _____

PRODUCER'S SIGNATURE DATE

_____ _____

PRODUCER'S NAME (PRINTED OR TYPED)

_____

PRODUCER'S ADDRESS (PRINTED OR TYPED)

_____

PRODUCER'S COMPANY (PRINTED OR TYPED)

Information on Policies or Contracts which may be replaced:

Company Name	Policy or Contract Number	Name of Insured

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CERTIFICATE DISCLOSURE FORM AND INSTRUCTIONS

PLEASE READ CAREFULLY. This information has been prepared for you so that you may make an informed decision on the use of any of your certificate values to fund the purchase of a new certificate. Please see page 2 of this form for explanatory notes and instructions as to how this form has been completed.

PART A - CURRENT CERTIFICATE INFORMATION ☐ LIFE ☐ ANNUITY

Certificate Owner's Name:		Certificate Number:
Current Death Benefit: $	Current Premium Amount: $	Mode of Payment:
Cash Surrender Value: $	Paid-up Addition Value: $	Dividend Value: $

(The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the certificate proposed in Part B below.)

PART B - PROPOSED CERTIFICATE INFORMATION ☐ LIFE ☐ ANNUITY

Initial Death Benefit: $	Proposed Premium Amount: $	Mode of Payment:
Proposed Effective Date:	Premium Payable to Age: or for:	Years

NOTE: If you are replacing your current certificate, or using 25% or more of your certificate values, you may request a WRITTEN comparison between your current certificate and the proposed certificate. The comparison is to illustrate the certificate values for both certificates.

PART C - SOURCE OF FUNDING FOR THE PROPOSED CERTIFICATE

☐ A loan in the amount of $ _____ will be taken from the value of your CURRENT CERTIFICATE, each _____ (mode), bearing a current loan interest rate of _____%.

☐ A partial surrender in the amount of $_____ will be taken from the value of your CURRENT CERTIFICATE, each _____ (mode).

☐ A dividend withdrawal in the amount of $ _____ will be taken from the value of your CURRENT CERTIFICATE, each _____ (mode).

PART D - YOUR CURRENT CERTIFICATE COULD TERMINATE

If the certificate values of your CURRENT CERTIFICATE are used as a source of funding for the purchase of an additional certificate, it is estimated that your CURRENT CERTIFICATE will terminate on _____ (date).

It is estimated that you will begin making premium payments for the PROPOSED CERTIFICATE from your own funds on _____ (date) in the amount of $ _____ to be paid each _____ (mode).

NOTE: Since the values and premiums stated on this form may change over time, the estimated date upon which you will need to begin making premium payments from your own funds for the PROPOSED CERTIFICATE may also change. Estimates as to dates when certificates will terminate or payments must begin assume the continuation of current (or guaranteed) factors, and such calculations are based upon the assumption that any premiums or interest due on loans are paid when due.

Certificate Owner Signature: _____ Date: _____

Producer/Agent or Company Officer Signature: _____ Date: _____

Florida Licensed Producer/Agent Number or Corporate Title _____

COMPLETE ONE FORM FOR EACH PREVIOUSLY ISSUED CERTIFICATE.
ANY REQUIRED REPLACEMENT AND SALES FORMS MUST ALSO BE COMPLETED.
ONE COPY IS DELIVERED TO THE CERTIFICATE OWNER AND ONE COPY MAINTAINED BY THE INSURER.

Any and all information applicable to the transaction shall be fully and completely disclosed on Form OIR-DO-1180. If the information requested does not apply to the transaction, the words "not applicable" or "N/A" shall be entered.

PART A

The information to be disclosed in Part A of Form OIR-DO-1180 shall apply to the current, in-force certificate for which certificate values are being utilized as a source of funding for the purchase of additional insurance contract (s). For purposes of this form, "current death benefit" is defined as the sum of the death benefit payable under the base certificate, all life insurance riders covering the principal insured (other than special contingency death riders), paid-up additional insurance and dividends, minus outstanding indebtedness. The term "cash surrender value" is defined as the cash value of the certificate or contract net of any outstanding indebtedness and surrender charges, and less any dividend value. The term "paid-up addition value" is defined as the cash value of additional insurance purchased with certificate dividends. The term "dividend value" is defined as the total cash value of all certificate dividends left on deposit with the company to accumulate at interest.

PART B

The information to be disclosed in Part B of Form OIR-DO-1180 shall apply to the proposed additional insurance contract{s) being funded by certificate values in a current, in-force certificate. For purposes of this form, "proposed premium amount" is defined as any recurring payment, which is planned to be paid, or which is required to be paid under the proposed certificate.

PART C

The information to be disclosed in Part C of Form OIR-DO-1180 shall apply to the current, in-force certificate, and shall indicate the manner in which the certificate values are being used to fund the purchase of the proposed certificate. Part C is not to be completed if the current certificate is totally surrendered. However, in the event of a total surrender the current certificate, Parts A, B, D, and the signature block of this form must still be completed. When completing Part C of this form, each and every source of funding for the proposed certificate must be identified, i.e., whether a certificate loan, partial surrender, or dividend withdrawal or any combination thereof is being utilized. If more than one source of funding will be utilized to fund the initial and/or future premiums for the proposed certificate, all applicable sections of Part C shall be completed. For purposes of this form, a "partial surrender" is defined as any amount taken from the value of the current certificate which is less than the total cash value available under such certificate. The term "mode" is defined as the frequency upon which a certificate loan, partial surrender or dividend withdrawal will be taken from the value of the current certificate. In the event of a single loan, surrender or withdrawal, the words "one time only" shall be entered in the space provided. The term "loan interest rate" is defined as the rate of interest in effect on the date that this form is completed, as specified in the current certificate contract.

PART D

The information to be disclosed in Part D of Form OIR-DO-1180 shall apply to the current, in-force certificate and the proposed additional certificate, respectively.

SIGNATURES

In order to evidence that the required disclosure has been made, Form OIR-DO-1180 shall be signed and dated by the soliciting agent or by a Corporate Officer, as well as by the certificate owner. For identification purposes, the agent or Corporate Officer shall enter his or her Florida License Number or Corporate title, respectively, in the space provided.

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Notice and Consent For Blood and Body Fluid Testing

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

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

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

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

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

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

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

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

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

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

_____

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

Name of Proposed Insured	Birthdate (mm/dd/yyyy)
Signature of Proposed Insured (Parent/Guardian)	State of Residency
Date Signed By Proposed Insured (Parent/Guardian) (mm/dd/yyyy)	

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

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

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Foresters

HIV Antibody Test Information Form For Insurance Applicant

AIDS

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

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

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

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

The HIV antibody test:
Before consenting to testing, please read the following important information:

1. (a) **"ELISA**" test means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus.

   (b) **"Positive ELISA test"** means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

   (c) **"Western Blot Assay"** means an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus.

   (d) **"Reactive Western Blot Assay"** means an Assay which is reactive according to the standards of performance and results specified in the manufacturer's federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

   (e) **"HIV antibody test"** means an ELISA test or a Western Blot Assay, or both.

2. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

3. **Positive test results.** If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

   Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:

   (a) **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.

   (b) **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

5. **Side effects.** A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

6. **Disclosure of results.** A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician, the State Health Department, or through a local community-based organization.

7. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

8. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

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

Foresters Financial

1035 Exchange/Absolute Assignment Form ("Form")

For Use with New Life Insurance Contracts Only

In order to qualify as an exchange under section 1035 of the Internal Revenue Code, the insured and owner of the new contract must be the same as the insured and owner of each existing contract. Complete a separate Form for each existing company whose life insurance contract(s) are being exchanged.

Insured's Name: _____

Owner's Name: _____ Owner's Social Security Number: _____

Existing Company: Name: _____

Address: _____
(*Street Address, City, State & Zip Code*)

Existing Contract(s) (Each life insurance contract listed below is designated for exchange):

Contract Number	Attached or Lost/Destroyed	Contract Number	Attached or Lost/Destroyed
	O Attached O Lost/Destroyed		O Attached O Lost/Destroyed
	O Attached O Lost/Destroyed		O Attached O Lost/Destroyed

Definitions: "Foresters", "we", "our", and "us" mean The Independent Order of Foresters. "I", "me" or "my" mean individually the owner and each person, if any, signing this Form as the spouse of the owner or as an irrevocable beneficiary. "New Contract" means the Foresters life insurance contract to which funds, if any, resulting from the exchange(s) requested in this Form are to be applied. "Existing Contract" means each life insurance contract designated in this Form for exchange.

For purposes of an exchange under Section 1035 of the Internal Revenue Code, I, as evidenced by my signature in this Form, declare, understand and agree that:

1. Effective the date, shown on this Form, that a Foresters authorized representative signs this Form, I, for value received, revoke all prior beneficiary designations and designate Foresters as sole beneficiary of each Existing Contract, and then assign and transfer, without limitation, to Foresters all right, title and interest in each Existing Contract, including its value payable upon surrender. Foresters is authorized to forward this Form to the Existing Insurer and request the surrender of the Existing Contract(s).
2. If the application for the New Contract is cancelled, declined, withdrawn or postponed or the New Contract is issued by us but not accepted by the Owner, (a) before we forward this Form to the Existing Company, then we will release this assignment or (b), after we forward this Form to the Existing Company, then we will, unless previously directed otherwise by the Owner, return the transferred funds received by us, if any, to the Owner and our liability and obligation under this assignment will end. There may not be a right to reinstate an Existing Contract after we have forwarded this Form to the Existing Company.
3. Coverage under the New Contract, if issued, will be effective only as described in, and subject to the terms of, the New Contract. If, as shown in Foresters records, I have not provided the first premium payment for the New Contract, separate from this exchange, the New Contract may not be issued until after the transferred funds have been received by Foresters. Coverage, if any, under a Temporary Insurance Agreement or Conditional Receipt provided by Foresters, if any, is subject to the terms of that agreement or receipt, and will not be affected by this assignment.
4. Each Existing Contract is in effect and no Existing Contract is subject to a prior assignment, bankruptcy or collection proceeding, federal or state levy or other legal action.
5. The Owner is responsible for and agrees to pay the premium(s) required, if any, to keep each Existing Contract in effect, according to the terms of that Existing Contract, until the transfer is completed. Failure to pay the premium(s) required for an Existing Contract may result in a loan, lower cash surrender value and/or a lapse, reduction or termination in coverage, under that Existing Contract.
6. An outstanding loan, if any, on an Existing Contract will not be transferred to the New Contract and a taxable gain, if any, that results from such loan(s) may be reported to the Internal Revenue Service by the Existing Company.
7. Foresters (a) is furnishing this Form and is participating in this transaction at my specific request and as an accommodation to me, (b) makes no representations concerning my tax treatment under Section 1035 of Internal Revenue Code or otherwise, and (c) has no responsibility or liability for the validity of the assignment(s) or transfer(s) made under this Form or my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.

 105690 US 07/12

Owner's Signature: X_____ Date *(mmm/dd/yyyy)*: _____

Owner's Spouse: *(If an Existing Contract was issued in a community property state then the owner's spouse must also sign this Form.)*

Name (print full name): _____

Signature: X_____ Date *(mmm/dd/yyyy)*: _____

Irrevocable Beneficiary(ies): *(If an Existing Contract has a beneficiary designated as irrevocable then each irrevocable beneficiary must also sign this Form.)*

Name (print full name): _____

Signature: X_____ Date *(mmm/dd/yyyy)*: _____

Name (print full name): _____

Signature: X_____ Date *(mmm/dd/yyyy)*: _____

Name (print full name): _____

Signature: X_____ Date *(mmm/dd/yyyy)*: _____

Acceptance of 1035 Exchange/Transfer (*to be completed by Foresters)*:

Foresters hereby accepts this assignment and subsequent transfer of funds under the terms described in this Form.

Authorized Signature: X _____ Date *(mmm/dd/yyyy)*: _____

Title: _____ New Contract Certificate Number: _____