Foresters

Application for life and critical illness insurance

Use this application to apply for:

- Term 10
- Term 20
- Term 30
- LifeCare Critical Illness insurance
- Familylife Participating Whole Life insurance
- Passport Universal Life insurance

Do not use the application to apply for EZ Term, Guaranteed Issue Whole Life, Easylife, or Health Security Plus.

Making an informed decision
If you want more information about the insurance coverage you are considering, you can view a sample policy at **www.foresters.com/CA-EN/Pages/Sample-Contracts.aspx**. Your insurance advisor can answer any questions you may have.

Please check if an Insured proposed in this application is a potential substandard risk or has previously been declined for insurance. If checked:

Complete the entire application.

Do not collect initial premium.

Do not order age/amount or paramedical requirements.

The Independent Order of Foresters
789 Don Mills Road, Toronto, ON M3C 1T9
1 (800) 828-1540

Foresters Life Insurance Company
1660 Tech Avenue, Suite 3, Mississauga, ON L4W 5S8
1 (800) 267-8777

Foresters™ is the trade name and a trademark of The Independent Order of Foresters, and its subsidiary Foresters Life Insurance Company is licensed to use this mark.

When to use this application

When applying for one policy or several on the same life, with or without a spousal rider.

When applying for a Joint First-to-die policy.

When you will need more than one application form

When applying for separate policies on two or more lives, complete separate applications for each insured.

Applications received in good order receive priority service.

To ensure priority service:

Complete the application in full, including any applicable supplementary forms, and ensure all questions are answered.

Submit applicable disclosure forms if replacing existing life insurance.

Attach an illustration for each policy applied for.

Print legibly in dark ink. Do not use ditto marks.

Do not make erasures or use liquid paper. If you stroke out an error, it must be initialed by each person signing the application.

Do not collect premium or release the Temporary Insurance Agreement if any Insured is over age 65 or younger than 15 days old, or if the total amount of either life insurance or critical illness insurance applied for exceeds $1,000,000 for any Insured.

1. Insured, owner and beneficiary information

1.1 Insured

In this application, Insured means a person who is proposed for life or critical illness insurance.

[1] If self-employed, or business owner, specify nature of business and duties. If not working, indicate reason, duration, and last occupation.

[2] SIN required only if the Insured will be an Owner and is applying for permanent life insurance.

Insured 1

First Name	Middle Name	Last Name
◯ Male ◯ Female	Date of birth (m/d/y)	Country of birth
Residential address (street name and number, apartment number)		
City	Province/Territory	Postal Code
Name of employer		Length of employment there
Occupation[1]		
Primary telephone	Work telephone	Social insurance number[2]

Insured 2 ◯ Joint First-to-die ◯ Spousal Rider

First Name	Middle Name	Last Name
◯ Male ◯ Female	Date of birth (m/d/y)	Country of birth
Residential address (street name and number, apartment number)	◯ Same as Insured 1 above	
City	Province/Territory	Postal Code
Name of employer		Length of employment there
Occupation[1]		
Primary telephone	Work telephone	Social insurance number[2]

1.2 Owner

Complete Owner details for each Owner who is not an Insured above.

An Owner must be at least 16 years old, or at least 18 in Quebec.

If this application is for Passport Universal Life, the Owner must be the Insured under the policy, unless the Insured is under age 16 (or under 18 in Quebec).

[1] SIN required only if applying for permanent life insurance.

Owner 1 is: ◯ Insured 1 ◯ Insured 2 ◯ Other individual or entity – complete Owner 1

Owner 2 is: ◯ Insured 1 ◯ Insured 2 ◯ Other individual or entity – complete Owner 2

Owner 1

Full legal name of individual (first, middle, last), or corporation/entity		
◯ Male ◯ Female	Date of birth (m/d/y)	Occupation
Address (street name and number, apartment number)		
City	Province/Territory	Postal Code
Primary telephone	Work telephone	Social insurance number[1]
Relationship to the Insured(s)		

Owner 2

Full legal name of individual (first, middle, last), or corporation/entity		
◯ Male ◯ Female	Date of birth (m/d/y)	Occupation
Address (street name and number, apartment number)	◯ Same as Owner 1 above	
City	Province/Territory	Postal Code
Primary telephone	Work telephone	Social insurance number[1]
Relationship to the Insured(s)		

1. Insured, owner and beneficiary information

1.3
Contingent Owner

Contingent Owner for Owner 1	Contingent Owner for Owner 2
Legal name of individual or corporation/entity	Legal name of individual or corporation/entity
Date of birth (m/d/y)	Date of birth (m/d/y)
Relationship to Owner 1	Relationship to Owner 2

1.4
Owner verification

Complete a separate *Identity Verification, Corporations and other Entities* form 105847 CAN for each Owner that is a corporation or other entity.

To comply with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act, the identity of Owners must be verified and the involvement of any third parties determined in section 1.5.

Owner 1	Owner 2
Document presented to verify identity: ○ Birth certificate ○ Provincial health card with photo and signature ○ Driver's license with photo and signature ○ Passport ○ Other (specify):	Document presented to verify identity: ○ Birth certificate ○ Provincial health card with photo and signature ○ Driver's license with photo and signature ○ Passport ○ Other (specify):
Document number	Document number
Place of issue Expiry date (m/d/y)	Place of issue Expiry date (m/d/y)

1.5
Third party determination

A third party is an individual or entity with an interest in the policy but is not an Insured or an Owner. Some examples of third parties include: premium payor, power of attorney, executor, and trustee.

If there are several third parties to be disclosed, complete a separate *Third Party Determination* form 105815 CAN for each one.

Is a third party involved with this application for insurance, or will a third party pay the insurance premiums or have the use of, or access to, the policy's cash value? If the answer is yes, provide the following information. ○ yes ○ no

Full legal name of third party (first, middle, last), or corporation/entity		Date of birth (m/d/y)
Type of third party	Relationship to Owners	
Detailed occupation or nature of business		
Address (street number and name)		
City	Province/Territory	Postal Code
Registration number if a corporation	Jurisdiction of incorporation	
If unable to provide the information above about a third party, provide details as to why:		

1.6
Application for membership

Is the Insured a Foresters member?

Insured 1	Insured 2
○ yes ○ no, consider this my application for membership	○ yes ○ no, consider this my application for membership

A Welcome to Foresters letter confirming membership will be included with the policy, if issued. For information about Foresters membership and benefits, visit **www.foresters.com.**

1. Insured, owner and beneficiary information

1.7 Beneficiary designation for life insurance

Please ensure Primary Beneficiary designations total 100% for each Insured.

To designate a beneficiary for the return of premium benefit under a Critical Illness insurance plan, complete instead our *Beneficiary Designations for LifeCare and Health Security Plus* form 105567 CAN

Revocable/Irrevocable designations: All beneficiaries are revocable unless otherwise stated. However, in Quebec, the designation of a legally married spouse of the Owner is irrevocable unless expressly stated to be revocable.

Do not name a minor as an irrevocable beneficiary. Once an irrevocable beneficiary has been named, his or her written consent is required for changes affecting the value of the policy; a minor cannot give that consent.

Primary Beneficiaries for Insured 1

Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 1 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %
Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 1 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %
Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 1 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %
Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 1 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %

Contingency Beneficiary for Insured 1

Full name (or legal name of corporation/entity)	Date of birth (m/d/y)
Relationship to Insured 1 (or to Owner in Quebec)	○ Revocable ○ Irrevocable

Primary Beneficiaries for Insured 2

Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 2 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %
Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 2 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %
Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 2 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %
Full legal name of individual or corporation/entity	Date of birth (m/d/y)	
Relationship to Insured 2 (or to Owner in Quebec)	○ Revocable ○ Irrevocable	Share %

Contingency Beneficiary for Insured 2

Full name (or legal name of corporation/entity)	Date of birth (m/d/y)
Relationship to Insured 2 (or to Owner in Quebec)	○ Revocable ○ Irrevocable

1.8 If a beneficiary is a minor

In all provinces except Quebec, a trustee should be named to receive funds on the minor's behalf.
In Quebec, the proceeds payable to a minor will be paid to the parent(s) (or other legal guardian, if applicable).
If you wish to have another person administering the child's proceeds, you should ensure you have the proper provisions in your will.

Name of trustee/administrator

Relationship to Owner(s)

2. Plan and benefit information

2.1 Term life insurance

If Children's Term Rider is selected, complete Section 6.

Amount of insurance $	○ Term 10	○ Term 20	○ Term 30
	○ Single Life	○ Joint First-to-die	
Insured: 1:	○ Term 10 Rider $	○ Term 20 Rider $	
Insured: 2:	○ Term 10 Rider $	○ Term 20 Rider $	
○ Accidental Death Benefit	Insured 1 $	Insured 2 $	
○ Children's Term Rider	Amount for each child $	○ Waiver of Premium	

2.2 Critical Illness insurance

Amount of insurance $	○ LifeCare T10	○ LifeCare T75
○ Juvenile Rider	$	○ ROP/RPU Rider

2.3 Familylife Whole Life insurance

If Children's Term Rider is selected, complete Section 6.

For Applicant Waiver of Premium, complete Section 7.

Basic amount of insurance $	Initial enhanced amount $	Total (basic + enhanced) $	
Dividend options:	○ Protector Option - complete Initial enhanced and Total amounts above		
○ Paid-up Additions	○ Dividends on Deposit	○ Premium Reduction	○ Paid in Cash
Premium paying period:	○ Pay to 100	○ 20-pay	
○ Children's Term Rider	Amount for each child $		
○ Accidental Death Benefit	$		
○ Guaranteed Insurability Rider	○ Waiver of Premium	○ Applicant waiver of Premium	

2.4 Passport Universal Life insurance

If Children's Term Rider is selected, complete Section 6.

Amount of Insurance $	Only Yearly Renewable Term Cost of Insurance available	
Death Benefit options	○ Level Insurance Amount	○ Insured Amount plus Total Account Value
○ Term 10 Rider $	○ Spousal T10 Rider $	
○ Guaranteed Purchase Option $	○ Accidental Death Benefit $	
○ Waiver of Specified Amount $	○ Waiver of Monthly Deductions	
○ Children's Term Rider		
Lump sum premium : $	**Planned premium: $**	○ Monthly ○ Annual

2.5 Passport Universal Life Premium allocation instructions

Lump sum premium	Planned premium	Account	
%	%	175	Daily Interest Account
%	%	171	1 Year Guaranteed Interest Account
%	%	172	3 Year Guaranteed Interest Account
%	%	173	5 Year Guaranteed Interest Account
%	%	174	8 Year Guaranteed Interest Account
%	%	181	Canadian Bond Index
%	%	182	Canadian Equity Index
%	%	183	Canadian Balanced Index Account
%	%	184	American Equity Index Account
%	%	185	International Index Account
100 %	**100 %**		

3. Personal information

3.1 Purpose of insurance

What are the main purposes of this insurance? Select all that apply.

- ○ Income replacement
- ○ Final expenses
- ○ Estate preservation
- ○ Other (specify):
- ○ Insure children
- ○ Mortgage protection
- ○ Business loan protection
- ○ Buy-sell agreement
- ○ Key person insurance

3.2 Insurance history

In Section 3, you and your means Insured 1 and Insured 2, individually, named in Section 1.

	Insured 1	Insured 2
A In the last 6 months, have you applied to another insurer for individual life, critical illness or disability insurance?	○ yes ○ no	○ yes ○ no
B Do you have individual life, accidental death, critical illness or disability insurance in force or pending with Foresters or another insurer? If yes, complete the following table:	○ yes ○ no	○ yes ○ no

Insured	Status	Year issued	Type of insurance	Personal or Business	Insurer	Amount
	○ Inforce ○ Pending			○ Personal ○ Business		$
	○ Inforce ○ Pending			○ Personal ○ Business		$
	○ Inforce ○ Pending			○ Personal ○ Business		$
	○ Inforce ○ Pending			○ Personal ○ Business		$
	○ Inforce ○ Pending			○ Personal ○ Business		$
	○ Inforce ○ Pending			○ Personal ○ Business		$

Ensure all disclosure requirements are completed if this application for life insurance is intended to replace existing insurance. Note that it is considered a replacement if you are replacing a Foresters policy with another Foresters policy.

	Insured 1	Insured 2
C If you are applying for more than one policy concurrently, are you placing only one policy?	○ yes ○ no	○ yes ○ no
D If no to Question C, what is the total amount of insurance to place with all insurers?	$	$
E Will you stop paying premiums, reduce the amount of coverage or discontinue existing life insurance coverage or an annuity if the insurance applied for in this application is issued? If yes, specify which plan, the insurer and the amount below, and complete the Comparison Disclosure Statement or Life Insurance Replacement Declaration required in your province.	○ yes ○ no	○ yes ○ no

Insured 1:

Insured 2:

	Insured 1	Insured 2
F Have you ever had an application for life, critical illness or disability insurance declined, rated, or modified? If yes, specify the insurer, the date and final decision below.	○ yes ○ no	○ yes ○ no

Insured 1: ○ declined ○ rated ○ modified

Insured 2: ○ declined ○ rated ○ modified

3.3 Status and residency of the Insured

	Insured 1	Insured 2
A Do you have Permanent Resident status in Canada? If no, provide details in 3.9 and a copy of your visa or work permit.	○ yes ○ no	○ yes ○ no
B How many years have you lived in Canada? If less than one year, specify the number of months.	○ years ○ months	○ years ○ months

3. Personal information

		Insured 1		Insured 2	
3.4 Criminal offences	Have you ever been charged with or convicted of a criminal offence, or is a criminal charge pending?	○ yes	○ no	○ yes	○ no
	If yes, identify and provide details for each charge in Section 3.9.				
3.5 Driving	**A** In the last 10 years, have you been convicted of a driving violation, or had your driver's license revoked or suspended, or is there a driving related charge pending?	○ yes	○ no	○ yes	○ no
	B In the last 10 years, have you been found guilty of, or is there a charge pending for, impaired, careless, reckless or negligent driving?	○ yes	○ no	○ yes	○ no
	If yes to either question, submit a completed Driving Questionnaire.				
3.6 Aviation	In the last 2 years have you flown, or do you plan to fly, an aircraft as a pilot, student pilot or crew member?	○ yes	○ no	○ yes	○ no
	If yes, submit a completed Aviation Questionnaire.				
3.7 Avocations	In the last 2 years have you engaged in, or do you plan to engage in, any of the following: All terrain vehicle use, motor vehicle racing (car, motorbike, snowmobile), bungee jumping, rodeo activity, snowboarding, sky diving, skin or scuba diving, ultra-light flying, hang gliding, rock or mountain climbing, heli-skiing, CAT or back country skiing, mixed martial arts, or a hazardous or extreme activity or sport?	○ yes	○ no	○ yes	○ no
	If yes, identify and provide details for each activity and frequency in section 3.9.				
3.8 Foreign travel	**A** Have you travelled outside of Canada or the United States in the last 12 months, other than to either Europe or the Caribbean for a vacation lasting 2 months or less?	○ yes	○ no	○ yes	○ no
	B Do you plan to travel outside of Canada or the United States in the next 12 months, other than to either Europe or the Caribbean for a vacation lasting 2 months or less?	○ yes	○ no	○ yes	○ no
	If yes to either question, submit a completed Foreign Travel questionnaire.				

3.9 Details

Use this area to provide details for questions 3.3 to 3.8.

Question	Insured	Details

4. Financial information

4.1 Insured's financial information

In Section 4.1, you and your means Insured 1 and Insured 2, individually, named in Section 1

	Insured 1	Insured 2
What is your annual earned income from employment, including self-employment?	$	$
What is your annual income from other sources?	$	$
If not self-supporting, what is your household annual earned income?	$	$
What is the gross amount of your personal assets?	$	$
What is the amount of your outstanding debts?	$	$
In the last 5 years, have you declared or been petitioned into personal or corporate bankruptcy?	○ yes ○ no	○ yes ○ no

If yes, specify date discharged (m/d/y):

Provide details/circumstances of bankruptcy

4.2 If an Insured is a minor

Complete if a child is named as an Insured in Section 1.1.

	Parent 1	Parent 2
What is the gross annual income earned by the minor's parents?	$	$
How much life and critical illness insurance do the minor's parents have? ○ None – indicate why not under details below.	$	$
How much life and critical illness insurance do the minor's siblings have? ○ No siblings ○ None – indicate why this application is being made to insure this minor.	**Sibling 1** $ **Sibling 3** $	**Sibling 2** $ **Sibling 4** $

Details

4.3 Business insurance

Complete if the insurance applied for is for business purposes, or if a business is an Owner or Beneficiary.

○ Corporation ○ Partnership ○ Sole proprietorship ○ Other

Nature of business		Year Established
Assets $	Liabilities $	Share of ownership
Net Worth $	Business fair market value $	**Insured 1:** %
Gross Annual Revenue $	Net annual after tax income $	**Insured 2:** %

Do other executives or partners in the business have life or critical illness insurance related to the business? If no, provide reason why below: ○ yes ○ no

If yes, provide details below:

▶ Name and title			% of business owned
Life insurance in force $	Life insurance pending $	Critical illness in force $	Critical illness pending $
▶ Name and title			% of business owned
Life insurance in force $	Life insurance pending $	Critical illness in force $	Critical illness pending $

In the last 5 years, has the business declared or been petitioned into bankruptcy? ○ yes ○ no

If yes, specify date discharged (m/d/y):

5. Health information

5.1 Medical information

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

Complete section 5.1 even if a paramedical is being ordered.

Sections 5.2 to 5.6 are optional if the paramedical exam is a routine age and amount requirement for this application.

If your regular physician does not have the most up to date records, provide the name, address and phone number of the physician, clinic or hospital who can complete your medical information in Section 5.5.

Insured 1

Height ○ ft/in ○ cm | Weight ○ lb ○ kg | Weight change in last year (specify) ○ none ○ gain ○ loss ○ lb ○ kg

Reason for weight change (if pregnant, specify due date)

Do you have a regular physician? ○ yes ○ no If yes, specify:

Physician's name	Date of last visit (m/d/y)
Physician's address	Physician's telephone

Reason for last visit to regular physician?

Result of last visit to regular physician?

In the last 5 years, have you seen a physician who is not your regular physician? If yes, specify. If more than one other physician, provide the following information for each additional physician in Section 5.5. ○ yes ○ no

Physician's name	Date of last visit (m/d/y)
Address of clinic or hospital	Telephone of clinic/hospital

Reason for last visit to other physician?

Result of last visit to other physician?

Insured 2

Height ○ ft/in ○ cm | Weight ○ lb ○ kg | Weight change in last year (specify) ○ none ○ gain ○ loss ○ lb ○ kg

Reason for weight change (if pregnant, specify due date)

Do you have a regular physician? ○ yes ○ no If yes, specify:

Physician's name	Date of last visit (m/d/y)
Physician's address	Physician's telephone

Reason for last visit to regular physician?

Result of last visit to regular physician?

In the last 5 years, have you seen a physician who is not your regular physician? If yes, specify. If more than one other physician, provide the following information for each additional physician in Section 5.5. ○ yes ○ no

Physician's name	Date of last visit (m/d/y)
Address of clinic or hospital	Telephone of clinic/hospital

Reason for last visit to other physician?

Result of last visit to other physician?

5. Health information

5.2 Medical information continued

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

If you answer yes to any question, **circle each applicable item** and provide details in Section 5.5.

Do you have, or have you ever had, or been told by a medical professional that you had, or received treatment, medication or advice for any of the following:	**Insured 1**	**Insured 2**
A Head and respiratory ▪ Optic neuritis ▪ Visual disturbance ▪ Blindness ▪ Glaucoma ▪ Deafness ▪ Tinnitus ▪ Loss of speech ▪ Sleep apnea ▪ Tuberculosis ▪ Sarcoidosis ▪ Cystic fibrosis ▪ Asthma ▪ Emphysema ▪ Recurrent bronchitis ▪ Spitting of blood ▪ Chronic obstructive pulmonary disease (COPD) ▪ Persistent hoarseness or cough ▪ A disorder, disease or condition of the eye, ear, nose, throat or lung not listed in Section 5.2 A (specify).	○ yes ○ no	○ yes ○ no
B Neurological ▪ Epilepsy or seizure ▪ Fainting ▪ Headaches ▪ Dizziness ▪ Stroke ▪ Tremor ▪ Multiple Sclerosis ▪ Cerebral Palsy ▪ Autism ▪ ADHD/ADD ▪ Loss of balance ▪ Loss of speech ▪ Dementia ▪ Tingling ▪ Huntington's chorea ▪ Parkinson's disease ▪ Alzheimer's disease ▪ Cognitive impairment ▪ Muscle Weakness ▪ Loss of sensation ▪ Developmental disorder ▪ Weakness of the extremities ▪ Transient ischemic attack (TIA) ▪ Motor neuron disease, including but not limited to ALS (Amyotrophic lateral sclerosis) or Lou Gehrig's disease ▪ A neurological disorder, disease or condition not listed in Section 5.2 B (specify).	○ yes ○ no	○ yes ○ no
C Psychological ▪ Anxiety ▪ Depression ▪ Bipolar disorder ▪ Panic attack ▪ Schizophrenia ▪ Burnout ▪ Eating disorder ▪ Mental impairment ▪ Attempted suicide or suicidal thoughts ▪ An emotional, behavioral or psychiatric disorder, disease or condition not listed in Section 5.2 C (specify).	○ yes ○ no	○ yes ○ no
D Heart and circulatory ▪ Chest pain ▪ Abnormal ECG ▪ Angina ▪ Heart attack ▪ Stroke ▪ Irregular pulse ▪ Palpitations ▪ Heart murmur ▪ Pacemaker ▪ High cholesterol ▪ Bypass or angioplasty ▪ Swollen ankles ▪ Blood clot ▪ Shortness of breath ▪ High blood pressure ▪ Aneurysm ▪ Transient ischemic attack (TIA) ▪ Peripheral vascular disease (poor circulation) ▪ A heart, blood vessel or circulatory system disorder, disease or condition not listed in Section 5.2 D (specify).	○ yes ○ no	○ yes ○ no
E Liver, stomach, bladder, kidney, or reproductive ▪ Hepatitis ▪ Hepatitis carrier ▪ Cirrhosis ▪ Jaundice ▪ Crohn's disease ▪ Diverticulitis ▪ Gall bladder ▪ Pancreatitis ▪ Blood in the stool ▪ Abnormal PAP smear ▪ Ulcer ▪ Prostatitis ▪ Sexually Transmitted disease ▪ Ulcerative colitis ▪ Frequently recurrent diarrhea and/or of long duration ▪ Abnormal prostate specific antigen (PSA) ▪ Blood, protein, or sugar in the urine ▪ Bleeding from the rectum ▪ Kidney disease, stones or nephritis ▪ A disorder, disease or condition of the stomach, pancreas, liver, intestine, kidney, bladder or ureter, prostate or male reproductive organs, uterus, ovary or cervix not listed in Section 5.2 E (specify).	○ yes ○ no	○ yes ○ no
F Breast, male or female ▪ Tumour, cyst or lump ▪ Fibrocystic disease ▪ Abnormal biopsy, mammogram or breast ultrasound ▪ A breast change or abnormality not listed in Section 5.2 F (specify).	○ yes ○ no	○ yes ○ no

5. Health information

5.2 Medical information continued

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

If you answer yes to any question, **circle the applicable item** and provide details in Section 5.5.

Do you have, or have you ever had, or been told by a medical professional that you had, or received treatment, medication or advice for any of the following:

Question	Insured 1		Insured 2	
G Blood, glandular or endocrine ▪ Goiter ▪ Anemia ▪ Abnormal blood sugar ▪ Diabetes ▪ Hemophilia ▪ Bleeding disorder ▪ Abnormality of the thyroid, pituitary, lymph or adrenal gland ▪ A blood or glandular disorder, disease or condition not listed in Section 5.2 G (specify).	○ yes	○ no	○ yes	○ no
H Muscle and skeletal ▪ Rheumatism ▪ Fibromyalgia ▪ Muscular dystrophy ▪ Gout ▪ Chronic fatigue ▪ Rheumatoid arthritis ▪ Paralysis ▪ Chronic pain ▪ Amputation ▪ Osteoarthritis or any other type of arthritis ▪ Systemic lupus erythematosus (SLE) or lupus in any form ▪ A spine, bone, joint or muscle disorder, disease or condition not listed in Section 5.2 H (specify).	○ yes	○ no	○ yes	○ no
I Cancer, growths, and skin disorders ▪ Tumour ▪ Leukemia ▪ Polyp ▪ Basal cell carcinoma ▪ Cysts or lumps ▪ Malignant melanoma ▪ Dysplastic nevi syndrome ▪ Enlarged lymph nodes ▪ Irregular shaped moles or lesions that have changed in appearance ▪ A type of malignancy, cancer or growth not listed in Section 5.2 I (specify).	○ yes	○ no	○ yes	○ no
J Immunological disorder ▪ An immunological disorder such as human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) ▪ Tested or advised to be tested for human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) ▪ Unexplained infection	○ yes	○ no	○ yes	○ no

5.3 Medical information continued

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

If you answer yes to any question, provide details in Section 5.5.

Question	Insured 1		Insured 2	
A Are you now under medical treatment, observation or investigation?	○ yes	○ no	○ yes	○ no
B Have you ever had an injury or disease or disorder, surgery, been hospitalized, tested for or treated for anything not listed in Section 5.2?	○ yes	○ no	○ yes	○ no
C Have you ever had, or been advised to have, a consultation, medical exam, MRI, CT scan, stress ECG, X-ray, ultrasound, colonoscopy, mammogram, blood test or diagnostic test not yet started, not yet completed, or the results of which are not yet known?	○ yes	○ no	○ yes	○ no
D Are you aware of symptoms or complaints regarding your health, or persistent or undiagnosed pain, for which a physician has not yet been consulted?	○ yes	○ no	○ yes	○ no
E Have you ever requested or received a pension, benefit or payment due to a disorder, disease, condition, injury or illness?	○ yes	○ no	○ yes	○ no
F Are you pregnant? If yes, provide estimated due date and details of any complications in Section 5.5.	○ yes	○ no	○ yes	○ no

5.4 Medications, drugs and alcohol

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

Question	Insured 1		Insured 2	
A Are you now taking herbal, holistic or prescribed medication? If yes, provide name, dosage and reason in Section 5.5.	○ yes	○ no	○ yes	○ no
B In the last 10 years, have you used any of the following: ▪ Cocaine ▪ Narcotic ▪ Amphetamine ▪ Heroin ▪ Ecstasy ▪ Barbiturate ▪ LSD ▪ Hallucinogen ▪ Opiate ▪ Tranquilizer or similar drug, or other controlled substance except as prescribed by a licensed physician or other medical practitioner? If yes, complete Drug Usage Questionnaire.	○ yes	○ no	○ yes	○ no
C In the last 3 years, have you consumed alcoholic beverages? If yes, specify:	○ yes	○ no	○ yes	○ no

	Beer	Wine	Liquor
Insured 1	bottles per ○ day ○ week ○ month	glasses per ○ day ○ week ○ month	oz/ml per ○ day ○ week ○ month
Insured 2	bottles per ○ day ○ week ○ month	glasses per ○ day ○ week ○ month	oz/ml per ○ day ○ week ○ month

5. Health information

5.4
Medications, drugs and alcohol

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

If you answer yes to any question, **circle the applicable item** and provide details in Section 5.5.

	Insured 1	Insured 2
D Have you ever decided to or been advised to decrease or stop your consumption of alcohol or drugs; or been treated for or been advised to join or joined an organization because of alcohol or drug use? If yes, complete the applicable Alcohol and Drug Usage Questionnaires.	◯ yes ◯ no	◯ yes ◯ no
E Have you used any of the following: ▪ Cigarettes, cigarillos, cigars, chewing tobacco, a pipe, snuff or other tobacco product; ▪ Smoking cessation product such as Zyban, Champix, nicotine patches or gum, e-cigarettes, or other; ▪ Marijuana, hashish, betel nuts, betel leaves, supari, paan, gutka, or shisha		
1 in the last 12 months?	◯ yes ◯ no	◯ yes ◯ no
2 in the last 24 months?	◯ yes ◯ no	◯ yes ◯ no
3 in the last 5 years? If yes, specify type, quantity and frequency in Section 5.5.	◯ yes ◯ no	◯ yes ◯ no
F How many cigars have you smoked in the last 12 months?	cigars	cigars

5.5
Details

Use this area to provide details for questions 5.1 to 5.4.

Include date, diagnosis, treatment, results and duration.

Also provide the names and contact information for each medical professional and medical facility.

Question	Insured	Details

5. Health information

5.5
Details continued

Use this area to provide details for questions 5.1 to 5.4.

Include date, diagnosis, treatment, results and duration.

Also provide the names and contact information for each medical professional and medical facility.

Question	Insured	Details

5.6
Family medical history

In Section 5, you and your means Insured 1 and Insured 2, individually, named in Section 1.

	Insured 1	Insured 2
Has your biological parent, brother or sister, whether living or dead, ever suffered from, or been diagnosed with, any of the following? ▪ Alzheimer's disease ▪ Cancer ▪ Diabetes ▪ Heart disease ▪ Hepatitis ▪ Stroke ▪ Mental illness ▪ High blood pressure ▪ Huntington's chorea ▪ Parkinson's disease ▪ Polycystic kidney disease ▪ Other kidney disorder ▪ Multiple sclerosis ▪ An inherited disease, disorder or condition not listed in Section 5.6 ▪ Motor neuron disease, such as but not limited to ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease	○ yes ○ no ○ unknown	○ yes ○ no ○ unknown

If yes, specify:

▶	○ father ○ mother ○ brother ○ sister of: ○ Insured 1 ○ Insured 2			
	Condition (if cancer, specify type)	Age at onset	Age if living	Age at death
▶	○ father ○ mother ○ brother ○ sister of: ○ Insured 1 ○ Insured 2			
	Condition (if cancer, specify type)	Age at onset	Age if living	Age at death
▶	○ father ○ mother ○ brother ○ sister of: ○ Insured 1 ○ Insured 2			
	Condition (if cancer, specify type)	Age at onset	Age if living	Age at death
▶	○ father ○ mother ○ brother ○ sister of: ○ Insured 1 ○ Insured 2			
	Condition (if cancer, specify type)	Age at onset	Age if living	Age at death
▶	○ father ○ mother ○ brother ○ sister of: ○ Insured 1 ○ Insured 2			
	Condition (if cancer, specify type)	Age at onset	Age if living	Age at death

If unknown, specify reason:

6. Children's term life insurance rider

6.1 Children

Complete this section for each child proposed for insurance under a Children's term life insurance rider.

Complete Section 6 of a separate application for any child proposed for insurance under this rider in addition to the three listed here.

Child 1

First name	Middle name	Last name	
○ Male ○ Female	Date of birth (m/d/y)	Age at nearest birthday	Country of birth
Height ○ ft/in ○ cm	Weight ○ lb ○ kg	Relationship to Insured 1 and/or Insured 2	
Date, reason and results of last visit to a physician, other medical advisor, clinic or hospital			

Child 2

First name	Middle name	Last name	
○ Male ○ Female	Date of birth (m/d/y)	Age at nearest birthday	Country of birth
Height ○ ft/in ○ cm	Weight ○ lb ○ kg	Relationship to Insured 1 and/or Insured 2	
Date, reason and results of last visit to a physician, other medical advisor, clinic or hospital			

Child 3

First name	Middle name	Last name	
○ Male ○ Female	Date of birth (m/d/y)	Age at nearest birthday	Country of birth
Height ○ ft/in ○ cm	Weight ○ lb ○ kg	Relationship to Insured 1 and/or Insured 2	
Date, reason and results of last visit to a physician, other medical advisor, clinic or hospital			

6.2 Children's physician

Provide same information for additional physicians in Section 6.4.

Name of children's regular physician	Date of last visit (m/d/y)
Physician's address	Physician's telephone
Name of child's specialist physician	Date of last visit (m/d/y)
Specialist's address	Specialist's telephone

6.3 Children's medical history

If you answer yes to any question, provide details in Section 6.4.

Question		
A Has an insurance application on a child ever been declined, postponed or modified?	○ yes	○ no
B Was a child born prematurely? If yes, identify the child and specify birth weight in Section 6.4.	○ yes	○ no
C Has a child been treated or tested for, or had a symptom or indication of autism, cancer, cerebral palsy, congenital heart disease, cystic fibrosis, Down's syndrome or muscular dystrophy?	○ yes	○ no
D Does a child have any other physical or mental impairment or a disease, disorder, condition, impairment or injury that required medication, treatment or surgery?	○ yes	○ no
E Is a child currently on medication, or has medication, treatment, blood work, specialist consultation, x-ray, ultrasound, EKG, CT or MRI scan, biopsy, scope or diagnostic test been advised that has not yet started, not yet been completed, or the results of which are not yet known?	○ yes	○ no
F Does each child named in 6.1 reside with either Insured 1 or Insured 2? If no, provide details below about whom the child lives with and how often the Insured sees the child.	○ yes	○ no

6.4 Details

Use this area to provide additional information for questions in Section 6.

Question	Name of child	Details

7. Applicant waiver of premium for Familylife

7.1 Owner applying for Waiver	○ **Owner 1**	Height ○ ft/in ○ cm	Weight ○ lb ○ kg	
	○ **Owner 2**	Height ○ ft/in ○ cm	Weight ○ lb ○ kg	
	Complete questions 7.2 to 7.8 for each Owner who is applying for the Applicant Waiver.			

		Owner 1	Owner 2
7.2	Is the Owner currently employed full time? If no, state number of work hours per week if part-time. Indicate reason for and duration of not working full time, and last occupation in Section 7.8. If self-employed, or business owner, specify nature of business and duties.	○ yes ○ no	○ yes ○ no
7.3 If you answer yes to any question, provide details in Section 7.8.	In the past 5 years, has the Owner:		
	A Consulted a physician; had an electrocardiogram, diagnostic test, or been in a clinic, hospital or medical office for observation or treatment?	○ yes ○ no	○ yes ○ no
	B Been advised to have a diagnostic test, hospitalization or surgery that was not done?	○ yes ○ no	○ yes ○ no
7.4 If you answer yes to any question, provide details in Section 7.8.	Does the Owner have, ever had, or had a symptom or indication of:		
	A Cancer, stroke, heart attack or heart disease, chest pain, angina, high blood pressure, heart murmur, a circulatory or blood disease, disorder or condition, asthma, emphysema, or respiratory disease, disorder or condition?	○ yes ○ no	○ yes ○ no
	B Diabetes, glandular or thyroid disorder, enlarged lymph node, epilepsy or a mental, nervous or neurological disorder, depression or anxiety?	○ yes ○ no	○ yes ○ no
	C Kidney, urinary or reproductive system disease, disorder or condition, liver or gastrointestinal disorder, hepatitis or hepatitis carrier state?	○ yes ○ no	○ yes ○ no
	D Loss of vision, amputation, deformity, arthritis, back pain requiring treatment or medication, or a musculo-skeletal disease, disorder or condition?	○ yes ○ no	○ yes ○ no
7.5	Has the Owner ever had a positive HIV test or been told they have acquired immune deficiency syndrome (AIDS), or an immunological disorder?	○ yes ○ no	○ yes ○ no
7.6	Is the Owner presently taking treatment or medication? If yes, provide details in Section 7.8.	○ yes ○ no	○ yes ○ no
7.7 If you answer yes to any question, provide details in Section 7.8.	Has the Owner:		
	A Ever had a request for life or disability insurance declined, postponed, rated or restricted?	○ yes ○ no	○ yes ○ no
	B Within the past two years, flown, or plan to fly, or taken instruction as a pilot or engaged, or plan to engage, in racing, scuba or sky diving, hang gliding or a hazardous or extreme sport or activity?	○ yes ○ no	○ yes ○ no
	C Within the past five years used an amphetamine, narcotic, barbiturate, hallucinogen, or marijuana, or received treatment or medication for alcohol or drug use?	○ yes ○ no	○ yes ○ no
	D Ever had their driver's license suspended, revoked, or within the past three years had three or more moving violations? If yes, provide details in Section 7.8 and driver's license number.	○ yes ○ no	○ yes ○ no
	D Plans to travel or reside outside of Canada for more than four consecutive weeks?	○ yes ○ no	○ yes ○ no

7.8 Details	**Question**	**Name of Owner**	**Details**

8. Premium and issue instructions

8.1 Premium payments

Cheques are payable to **Foresters**.

If making a lump sum premium payment of $100,000 or more for a permanent life insurance policy, complete a *Politically Exposed Foreign Persons Questionnaire* form 105817 CAN.

Important information for the advisor: Do not collect premium or release the Temporary Insurance Agreement if either Insured 1 or Insured 2 is over age 65 or younger than 15 days old, or if the total amount of either life insurance or critical illness insurance applied for exceeds $1,000,000.

If applying for a product with preferred underwriting classes, the applicable premium at Standard rates must be submitted for the TIA to take effect.

Initial premium

○ Draw initial premium by pre-authorized debit (PAD), or

○ Initial premium submitted by cheque with this application (specify): $

Policy premium payment frequency and method: ○ Annual Billing ○ Monthly PAD

For monthly PAD withdraw premiums from:

○ Same account as Foresters policy number: ______________________

○ Account shown in the attached void cheque

○ Void cheque is not available. Please use the following banking information:

Transit number	Bank number	Account number	○ Chequing ○ Savings

Name of financial institution

Address

City	Province/Territory	Postal Code

Monthly draw date requested: ○ 1st ○ 8th ○ 15th ○ 22nd

If no date is specified, the monthly draw will coincide with the policy date.

8.2 Issue instructions

○ Backdate to save age (up to 6 months from the date of underwriting approval for life insurance or 3 months for critical illness insurance) — Specify date (m/d/y)

○ Special dating instructions

If this is a joint application and an Insured is declined:

○ Issue coverage on the approved single life (default) ○ Close file

If underwriting decision is less favourable than as applied for:

○ Issue with applied for amount ○ Contact advisor for direction (default)

Concurrent applications on the life of a family member or partner

○ Issue my coverage as soon as it is approved (default if not specified)

○ Hold issue until you approve coverage on the life of:

8.3 Language and mailing address

Issue the policy and future communications ○ in English ○ en français

Send statements and future communications to (specify only one):

○ Address of Owner 1 ○ Address of Owner 2 ○ Address of third party specified in Section 1.5

○ Other:

Mailing address (street name and number, apartment number)

City	Province/Territory	Postal Code	Country

8.4 Additional contact information (optional)

Please provide an email address. If the Insured is a minor, provide the custodial parent's email address instead:

Insured 1:

Insured 2:

8. Premium and issue instructions

8.5 Pre-authorized Debit Plan Agreement ("Agreement")

For purposes of this Agreement: "Insurer" means, as applicable, each of The Independent Order of Foresters and Foresters Life Insurance Company; "Policy" means a certificate or policy issued by an Insurer and includes each rider that is attached to it.

The payor, by signing below, verifies that the payor is an account holder of the account identified on the attached VOID cheque or in Section 8.1 of this Foresters Application for Life and Critical Illness Insurance ("Application") and agrees that:

1. The Insurer issuing a Policy is authorized to make deductions monthly under this Agreement from that account or another account later identified or substituted by the payor for premium and insurance charges for each Policy issued by that Insurer in response to this Application;
2. The financial institution from which the deductions are to be made is authorized to treat each deduction by the Insurer as though the payor made it personally;
3. The Insurer reserves the right to determine when the first deduction, if any, will be made and the amount of that deduction for each Policy issued by it; the subsequent deduction amounts may be variable.
4. This Agreement is effective immediately and will continue until terminated, which either the payor or the Insurer may do at any time by providing notice of at least 30 days to the other. Payor may obtain a sample cancellation form or further information on the right to cancel a PAD Plan Agreement at his/her financial institution or by visiting www.cdnpay.ca;
5. Should funds not be available due to insufficient funds, the Insurer may, at its option, draw from the payor's account on the next scheduled withdrawal date for the insufficient amount applicable to each Policy while that Policy is in effect;
6. The payor has certain recourse rights if any debit does not comply with this Agreement. For example, the payor has the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on recourse rights, the payor may contact his or her financial institution or visit www.cdnpay.ca; and
7. The payor may contact the Insurer at its address and phone number:
   Attention: Policy Owner Services
   Foresters, 1660 Tech Avenue, Suite 3, Mississauga, ON L4W 5S8, 1-800-267-8777

The payor waives the right to receive pre-notification of the amount and date of the first deduction and of a change in the deduction amount required as premium or charges for each Policy in effect, or a change in amount requested by the payor by whatever means.

The bank account holder must sign this PAD Plan Agreement as his/her name appears on bank records for the account provided.

Monthly deductions under this Agreement are: ○ Personal ○ Business related

Signature of account holder Date (m/d/y)

X

Signature of joint account holder Date (m/d/y)

X

9. Application for temporary insurance

9.1 Temporary insurance questions

In Section 9.1, you and your means Insured 1 and Insured 2, individually, named in Section 1.

No advisor is authorized to modify the Temporary Insurance Agreement (TIA) in any way.

Question	Owner 1		Owner 2	
A Are you over the age of 65 or less than 15 days old?	○ yes	○ no	○ yes	○ no
B Has an application for insurance on your life ever been rated, declined or modified?	○ yes	○ no	○ yes	○ no
C Have you ever been treated for or had an indication, sign or symptom of cancer, tumour, stroke, heart disease, blood vessel disorder or disease, diabetes, loss of speech, loss of limb, severe burns, deafness, blindness, current or recurring kidney, liver, lung disorder, Alzheimer's, Huntington's or Parkinson's disease, or a disease or disorder of the nervous system?	○ yes	○ no	○ yes	○ no
D Have you ever had or been told you have acquired immune deficiency syndrome (AIDS), positive HIV test, or a disorder or disease of the immune system?	○ yes	○ no	○ yes	○ no
E Within the last 2 years, have you been hospitalized (except for childbirth)?	○ yes	○ no	○ yes	○ no
F Within the last 6 months, has a disorder, disease, injury or illness prevented you from performing your regular activities or caused you to be absent from work for more than 7 consecutive calendar days?	○ yes	○ no	○ yes	○ no
G Are you aware of a symptom, illness or complaint for which you have not yet sought medical advice, or for which treatment or test is recommended, planned or pending?	○ yes	○ no	○ yes	○ no

9.2 Understanding and agreement

In Section 9.2, you and your means each Insured and Owner, individually, named in Section 1.

Do you agree that temporary insurance, if applicable, is subject to the Temporary Insurance Agreement (TIA) and Receipt included with this application form 105849 CAN, regardless of whether:

a) the TIA was or was not left with an Insured or an Owner, and

b) a premium was or was not provided, by any method, with this Application, or a premium was subsequently collected by us?

Insured 1		Insured 2	
○ yes	○ no	○ yes	○ no
Owner 1		**Owner 2**	
○ yes	○ no	○ yes	○ no

10. Agreements and authorizations

10.1 Agreement

"Application" means this Foresters Application for Life and Critical Illness Insurance. "I/me" means individually each person identified in this Application as an insured, owner or the parent/legal guardian signing this Application in relation to a minor child. "Insured" means each person identified as either Insured 1 or Insured 2 in this Application. "Insurer" means each of The Independent Order of Foresters and Foresters Life Insurance Company. "Owner" means each person identified as either Owner 1 or Owner 2 in this Application. "Policy" means a certificate or policy issued by an Insurer and includes each rider that is attached to it.

I, by signing this Application, agree that:

1. The statements and answers contained in this Application, and other evidence of insurability signed or provided by me, are true and complete and will be relied upon by each Insurer in deciding whether to issue a Policy.
2. A Policy issued, if any, by an Insurer will only come into effect according to the terms of that Policy that may include factors such as the date the application was approved, the Policy issue date, payment of the first premium and provided there is no change in insurability as described in the Policy.
3. No advisor, medical examiner or any other person has authority to advise that any untrue or incomplete answer or information is acceptable and has no power, except for Foresters President or Executive Secretary, or successor positions, to make, modify or discharge a Policy.
4. For each Policy issued by The Independent Order of Foresters, its Instruments of Incorporation and Constitution now in force or subsequently amended shall form part of the entire contract.
5. If signing this Application with respect to a child, I confirm that I have the authority to consent to the insurance applied for in this Application, and issued, if any, on that child's life.
6. The language of each Policy issued as a result of this Application and all correspondence shall be the same as that of this Application unless otherwise requested in Section 8.3.
7. If the Policy is either Passport or Familylife and Insured 1 is under age 16 at Policy issue, Insured 1 will become the owner of that Policy upon their 16th birthday.
8. I have received a copy of the Important Notices page.

I further understand and agree that:

1. Changes or corrections made to this Application, if any, by an Insurer are ratified by each Owner if the Policy delivered to an Insured or Owner is not returned to the Insurer during the cancellation period. Such changes or corrections may be made directly on this Application or by an amendment to this Application.
2. This Application and related documents may be completed, signed and/or submitted to each Insurer by voice and/or electronic means, including but not limited to, e-mail and facsimile transmission.
3. Each Insurer 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.
4. If I have chosen to provide a current internet e-mail address or other electronic contact information in this Application or choose to provide such address or contact information in the future, each Insurer may use that address or contact information to send messages, information or documents to me electronically relating, directly or indirectly, to this Application, an Insurer, Policy, membership, event, benefit, claim, administration or other goods and services.

10. Agreements and authorizations

10.2 Authorization

A photocopy of this authorization shall be as valid as the original.

The following definitions apply for purposes of this Authorization: "Application", "I/me", "Insured", "Insurer", "Owner" and "Policy" has the same meaning as defined in the Agreement subsection of this Application. "Authorized Person" means each Insurer, reinsurer, advisor, insurance agency, managing general agency and market intermediary related to this Application or a Policy and the respective parent, affiliates and authorized representatives of each and those performing services on behalf of one or more of the preceding in relation to an Authorized Purpose or this Application, Policy, benefit claim, membership or management of the respective business of each. "Authorized Child" means each person proposed for insurance in this Application who is under age 16 (18 in Quebec) and for whom I am signing this Application as the parent or legal guardian of that person. "Authorized Purpose" means: assessing or servicing or administering insurance coverage, each Policy, claim or the benefits of membership; identity verification, auditing, data loss analysis, compliance; tax reporting; informing of the benefits of membership; to assess and offer other products and services; any other purpose as required or permitted by law.

Other products and services

Your consent in relation to offering other products and services is optional.

If you do not want to provide your consent for that purpose, check here ◯
or write to our Chief Privacy Officer at: Foresters, 789 Don Mills Rd., Toronto, ON M3C 1T9.

Sharing additional information with your advisor

Do you, the undersigned, authorize the Insurer, at its discretion, to share the following information with your advisor about you and each Authorized Child if that information affects that Insurer's decision about whether to insure you or an Authorized Child and, if so, on what basis:

- That Insurer's findings about blood pressure, cholesterol level or physical build, and
- Information in this Application, supplementary questionnaire, paramedical interview or other evidence of insurability?

Insured 1	Insured 2	Owner 1	Owner 2
◯ yes ◯ no	◯ yes ◯ no	◯ yes ◯ no	◯ yes ◯ no

Collection, use and release of information

I, by signing this Application, authorize on my own behalf and on behalf of each Authorized Child, the collection, use and disclosure of information about me and each Authorized Child as follows: For Authorized Purposes by and between Authorized Persons and to or from health professionals, physicians, hospitals, clinics, medically related facilities, employers, government agencies, provincial health care plans and motor vehicle departments, insurance entities, MIB Inc., pharmacies, pharmacy benefit managers, benefit administrators, financial institutions, investigative or consumer reporting agencies, law enforcement agencies, insurers, reinsurers, beneficiary, claimant; Each Insurer may make a brief report about me and each Authorized Child to MIB, Inc. even if this application is cancelled or withdrawn and provide my medical information to the regular physician identified in section 5 of this Application and each Authorized Child's medical information to the regular physician identified in section 6 of this Application.

Each person signing this authorization may, by written notice to an Insurer, revoke their authorization in relation to that Insurer. Revoking authorization, however, will not affect action(s) begun before receipt of notice or prevent that Insurer from using personal information to administer a Policy, report to MIB, Inc., or to inform of or administer the benefits of membership.

10.3 Signatures

I understand and agree that my signature below applies to, and is for the purposes of, this entire Application.

Signature of Insured(s)
Must be at least 16 years old, or at least 18 in Quebec.

Signature of Insured 1	Signed in province/territory	Date (m/d/y)
X		

Signature of Insured 2	Signed in province/territory	Date (m/d/y)
X		

Signature of Owner(s)
If not signing above.

Signature of Owner 1	Signed in province/territory	Date (m/d/y)
X		

Signature of Owner 2	Signed in province/territory	Date (m/d/y)
X		

Signature of parent or legal guardian
If not signing above

Signature of parent or legal guardian of an Insured who is under age 16 (18 in Quebec)	Signed in province/territory	Date (m/d/y)
X		

Advisor

Signature of advisor	Print name of advisor
X	

Familylife and Passport are underwritten by The Independent Order of Foresters, 789 Don Mills Rd., Toronto, ON M3C 1T9. Term and LifeCare Critical Illness insurance are underwritten by Foresters Life Insurance Company 1660 Tech Avenue, Suite 3, Mississauga, ON L4W 5S8.

Foresters™ is the trade name and a trademark of The Independent Order of Foresters and its subsidiary Foresters Life Insurance Company is licensed to use this mark.

11. Advisor's report

11.1 Advisor information

Advisor name (first, middle, last)		
Advisor code	Agency code	Split %
Advisor name (first, middle, last)		
Advisor code	Agency code	Split %
Advisor name (first, middle, last)		
Advisor code	Agency code	Split %

11.2 Relationship to Insured and disclosure

	Insured 1	Insured 2
How many years have you known each Insured?	years	years
If you are related to an Insured, what is the nature of your relationship?		

Who initiated this application?
○ Owner ○ Insured ○ Advisor ○ Other (specify):

Did you meet with the Owner(s) and Insured(s) in person? ○ yes ○ no
If no, provide details:
○ Telephone and/or mail (please order paramedical) ○ Video conference/Skype

Do you know of any information not disclosed in this application that could impact the insurability of an Insured? If yes, provide details: ○ yes ○ no

Is this policy being purchased with the intent of transferring ownership in the policy? If yes, provide details: ○ yes ○ no

11.3 Requirements ordered

Do not order requirements for an Insured who has previously been declined by an insurer.

	Insured 1	Insured 2		Insured 1	Insured 2
Vitals	○	○	Medical exam	○	○
Urine HIV	○	○	Electrocardiogram	○	○
Blood Profile	○	○	Treadmill ECG	○	○
Paramedical exam	○	○			

Name of paramedical provider	Order number
Who should be contacted for an Inspection Report?	Best time to contact?

11.4 Signature of advisor who completed this application and advisor's report

I provided to the Owner(s) and Insured(s) the Important Notices page and a statement of disclosure outlining the companies I represent, the fact that I receive compensation for the sale of life and health insurance company products, and that I may receive additional compensation in the form of bonuses, conference programs or other incentives. I have also disclosed any conflicts or potential conflicts of interest with respect to this transaction.

To the best of my knowledge and belief, the information provided in the application is current, correct and complete. I am not aware of any additional information that is material to the underwriting and acceptance of this insurance application that has not been disclosed in this application or advisor's report.

I have verified the identity of the Owner(s). I confirm that the identification details provided in this application match the original identification documents shown to me, and that reasonable effort was exercised to determine if each Owner is acting on behalf of a third party. If I suspect that an undisclosed third party is involved, I will within a reasonable time email details to **compliancecda@foresters.com**.

Signature of advisor **X**	Date (m/d/y)
Signature of training supervisor where required **X**	Date (m/d/y)
Signature of servicing advisor if different from above I have reviewed this application and advisor's report. **X**	Date (m/d/y)

Important Notices

Notice Regarding MIB

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however make a brief report on it to MIB Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If a person named in this application applies to another MIB member company for life, disability or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that 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 about you in its file. If you question the accuracy of the information about you in the MIB file, you may contact MIB and seek a correction. The address of MIB's information office is: MIB, 330 University Avenue, Toronto, Ontario M5G 1R7. Its telephone number is (416) 597-0590 and website is www.mib.com.

Your Personal Information and Your Privacy

Respecting your privacy is important to us at Foresters. We will maintain your Personal Information in a confidential file to be used at our offices to provide you with our products and services and information about your Foresters membership. Information in your file will be collected, used and disclosed, on a continuing basis, by Foresters, our employees, reinsurers, agents and representatives, service providers or professional consultants to determine your eligibility for our products and services; to assess or administer claims; to administer your policy and address your questions; to tell you about, and provide, the benefits of membership; provide you with information about products, services or member benefits that may meet your needs; to help us continually improve our services and develop programs for our members; and as further described in the Authorization section of the Foresters Application for Life and Critical Illness Insurance signed by you. We will restrict access to your file to our employees, service providers, representatives, affiliates and reinsurers who need the information in the performance of their duties for us and to any person or organization to whom you gave consent. Our employees, service providers, representatives, reinsurers and any of their service providers may be located outside Canada. As such, your Personal Information may be subject to the laws of other jurisdictions and may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in those countries. You are entitled to access your Personal Information contained in your file and, when applicable, to have it corrected. You may also ask us not to send you information about our products, services or member benefits. To do either of these, please write to Foresters at 789 Don Mills Road, Toronto, Ontario, M3C 1T9. To access our most recent Privacy Policy, please visit our website at www.foresters.com.

Advisor Disclosure Statement

The advisor identified in the Foresters Application for Life and Critical Illness Insurance is an independent licensed insurance advisor authorized by the insurer, being either or both of the Foresters Life Insurance Company and/or The Independent Order of Foresters, to take an application in relation to the product you applied for in that Application and that is offered by that insurer. If the insurer issues a policy in response to the Application, the advisor will be entitled to receive compensation from that insurer that may include first year and/or annual service commission, bonuses, conference programs or other incentives.

Making an informed decision

If you want more information about the insurance coverage you are considering, you can view a sample policy at **www.foresters.com/CA-EN/Pages/Sample-Contracts.aspx**. Your insurance advisor can answer any questions you may have.

About Foresters

For over 135 years, Foresters has shared our financial strength with our members and their communities. Our financial strength, as measured by A.M. Best Company, is rated "A" (Excellent) and has been for the past thirteen years. This independent rating assesses our ability to pay claims and is an important measure of our strength and stability. An "A" (Excellent) rating is assigned to companies that have a strong ability to meet their ongoing obligations to policyholders and have, on balance, excellent balance sheet strength, operating performance and business profile when compared to the standards established by A.M. Best Company. In assigning Foresters rating on July 3, 2013, A.M. Best stated that the rating outlook is "stable", which means it is unlikely to change in the near future. See ambest.com for the latest ratings.

Foresters is more than a life insurance provider. We don't have shareholders. Instead, we invest in you, your family and in communities. Our purpose is to champion the well-being of families through quality life insurance, unique member benefits and inspiring community activities. Foresters member benefits are non-contractual, subject to benefit specific eligibility requirements and limitations and may be changed or canceled without notice. For more information, visit foresters.com.

Detach this page and leave with Owner 1

Temporary Insurance Agreement and Receipt

Definitions

Insured and Owner means each person identified as an Insured and/or Owner, respectively, in Section 1 of the Application. Application means the Foresters Application for Life and Critical Illness Insurance signed by, or on behalf of, each Insured and Owner. TIA means this Temporary Insurance Agreement and Receipt. Insurer means each of The Independent Order of Foresters and Foresters Life Insurance Company. Covered Impairment means the definition or description of covered impairment in the applicable critical illness insurance policy applied for in the Application.

Pre-conditions for Temporary Insurance

Subject to the terms of this TIA, temporary insurance will be provided to each Insured if each of the following pre-conditions is met:

1. Each Insured is older than 14 days and younger than 66 years on the date this TIA is signed by the advisor.
2. Each of the questions in the Application for temporary insurance section of the Application is answered "no", and the "no" answers shown are truthful.
3. At least 1/12th of the total annual premium for each policy applied for is provided with this Application either by cheque or pre-authorized debit that is honoured on presentation to the financial institution from which it is to be collected. That total annual premium amount must be based on standard rates, even if applying for a Policy with preferred underwriting classes.
4. Each Insured and Owner signed the Application on or before the date this TIA is signed by the advisor.

If one or more pre-condition is not met, no temporary insurance takes effect even if this TIA was left with either an Insured or Owner and/or premium was provided or a premium was collected by us.

When Temporary Insurance Begins and Ends

If each pre-condition is met, temporary insurance under this TIA will be in effect beginning on the date and time this Agreement is signed by the advisor and will end automatically, and no longer be in effect, on the earliest of the following, as shown in an Insurer's records:

a. The 90th day from the date this temporary insurance begins;
b. The date that insurance takes effect under the policy applied for;
c. The date a policy, other than applied for, is offered by an Insurer;
d. The date the application is withdrawn, cancelled, suspended or declined, whether orally or in writing;
e. The later of the date an Insurer sends notice to an Insured or Owner, and the date shown on such notice, terminating this TIA; and
f. The date the cheque submitted, or pre-authorized debit provided, with the Application is not honoured on presentation.

Limitations and Exclusions

1. There is no temporary insurance for the death of an Insured if only critical illness insurance is applied for in the Application for that Insured.
2. There is no temporary insurance for a Covered Impairment of an Insured if critical illness insurance is not applied for in the Application for that Insured.
3. This TIA shall be void and each Insurer's liability is limited to a refund of the payment collected by that Insurer in relation to the Application where: (a) There is fraud, material misrepresentation or nondisclosure in the Application or in a document submitted as evidence of insurability such as, but not limited to, a paramedical report or questionnaire; or (b) the death or Covered Impairment results from any of the following: suicide or suicide attempt, respectively; self-inflicted injury; voluntary or involuntary ingestion or administration of a drug, whether prescribed or not; alcohol or an alcohol or drug related condition.
4. There is no temporary insurance for the following Covered Impairments: (a) cancer, (b) brain tumour, or (c) a Covered Impairment that an Insured is first diagnosed with while this TIA is in effect but that Insured does not survive 30 days from the date of that diagnosis.

Entire Agreement

This TIA contains the entire terms regarding temporary insurance. No person, including the advisor, is authorized to waive, amend or modify the terms of this TIA.

Benefit Payment

Subject to the terms of this TIA:

1. If the Insured dies while this TIA is in effect and that Insured applied for life insurance in the Application, the Insurer that underwrites that life insurance applied for shall pay in the aggregate, under this TIA and all other temporary insurance in effect for that Insured with that Insurer as of that Insured's date of death, the lesser of $500,000 and the amount of that life insurance applied for in the Application. That amount payable shall be paid according to the beneficiary designation(s) in the Application.
2. If the Insured is first diagnosed with a Covered Impairment while this TIA is in effect and that Insured applied for critical illness insurance in the Application, the Insurer that underwrites that critical illness insurance shall pay in the aggregate, under this TIA and all other temporary insurance in effect for that Insured with that Insurer as of the date first diagnosed, the lesser of $500,000 and the amount of that critical illness insurance applied for in the Application. That amount payable shall be paid in equal shares to each Owner.

It is acknowledged that the sum of $ ____________ was provided or authorized when the Application was completed and signed.

Advisor name	Signature of Advisor	Date (m/d/y)
	X	