

The Independent Order of Foresters ("Foresters")  
 789 Don Mills Road.  
 Toronto, Canada M3C 1T9

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

www.foresters.com  
 T. 800 828 1540



A Fraternal Benefit Society.

## Application for Accidental Death Term Insurance

Proposed Insured				
First name	Middle name	Last name		Sex: <input type="radio"/> Male <input type="radio"/> Female
Street address		City	State	Zip code
Home phone #	Date of birth (mmm/dd/yyyy)	State & Country of birth	Social security #	Foresters member? <input type="radio"/> Yes <input type="radio"/> No, applying for membership.
Email address (optional)	Occupation & duties			
Current employment status: <input type="radio"/> Full time (30+ hrs per week past 6 months). <input type="radio"/> Part time (less than 30 hrs per week past 6 months). <input type="radio"/> Seasonal (less than 26 weeks a year at 30+ hrs per week). <input type="radio"/> Not currently employed.				Income (past 12 months): \$ _____
Beneficiary Information <i>(Each beneficiary below is revocable. If, however, a beneficiary is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary.)</i>				
Name of each primary beneficiary		Relationship to proposed insured	% Share	
			total	
			must equal 100%	
Name of each contingent beneficiary		Relationship to proposed insured	% Share	
			total	
			must equal 100%	
Insurance Applied For				
Foresters Prepared (Accidental Death Term Insurance): Insurance amount: \$ _____				
Optional rider coverage: <input type="radio"/> Disability Income (Accident Only): \$ _____ <input type="radio"/> Return of Premium <input type="radio"/> Waiver of Premium (Accident Only)				
Anticipated premium (based on insurance applied for and payment mode selected): \$ _____				
Health and Lifestyle Questions For purposes of the following questions "you" means the proposed insured, "diagnosed" means by a licensed physician or medical practitioner.				
1. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?				<input type="radio"/> Yes <input type="radio"/> No
2. 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?				<input type="radio"/> Yes <input type="radio"/> No
3. Have you ever been diagnosed with a terminal illness? (Terminal illness means an illness that would reasonably be expected to cause death within 24 months.)				<input type="radio"/> Yes <input type="radio"/> No
<i>(Complete questions 4 &amp; 5 only if applying for Disability Income (Accident Only) coverage.)</i>				
4. Are you currently disabled or have you, within the past 5 years, been unable to work at your regular job for more than 20 consecutive days?				<input type="radio"/> Yes <input type="radio"/> No
5. Do you have existing disability income insurance? If "Yes", indicate total amount of existing disability income coverage: \$ _____ (monthly)				<input type="radio"/> Yes <input type="radio"/> No
Other Insurance				
6. Will the insurance applied for in this Application replace, reduce coverage of, or modify premiums paid for, existing accident or sickness insurance?				<input type="radio"/> Yes <input type="radio"/> No
Ohio Guaranty Association Notice				
Foresters™ is a fraternal benefit society licensed to do business in the state of Ohio. As membership organizations, fraternal benefit societies are not included in the Ohio Guaranty Association. This means that fraternal benefit societies cannot be assessed for the insolvency of other life insurers or other fraternal benefit societies. By law, a fraternal benefit society is responsible for its own solvency. If there is an impairment of reserves, certificate holders may be assessed a proportionate share of the impairment. This process is described in certificates issued by Foresters.				

Payment Information			
First premium payment to be made by:	<input type="radio"/> Draft via Pre-Authorized Check (PAC)	<input type="radio"/> Check (payable to Foresters)	
Subsequent premium payments to be made by:	<input type="radio"/> PAC	<input type="radio"/> Direct Bill	
Payment mode:	<input type="radio"/> Monthly (PAC only)	<input type="radio"/> Quarterly	<input type="radio"/> Semi-annually <input type="radio"/> Annually

**Check Conversion Notification:** Foresters may process a check provided for payment as a check transaction or we may, at our option, use the information from the check to make a one-time electronic fund transfer from the account that the check relates to.

PAC Banking Information <i>(Complete if premium payments are to be made via PAC.)</i>	
<b>PAC banking information (including drafting first premium, if selected above) to be taken from:</b>	
<input type="radio"/> Attached void check. <input type="radio"/> Check submitted with this Application. <input type="radio"/> Information completed below (if no check available).	
Account Type:	<input type="radio"/> Checking <input type="radio"/> Savings
Name of financial institution:	_____
Street address:	_____
City:	_____ State: _____ Zip: _____
Transit #:	_____ Account # : _____

**PAC Authorization**

The proposed insured, by signing this application verifies that they are the account holder of the account identified in the PAC banking information section and agrees that: 1) Foresters is authorized to draft deductions under the PAC plan from that account or another account later identified or substituted by them. 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 account holder. 3) Foresters reserves the right to determine when the first deduction, if any, will be made and the amount of that deduction for the insurance contract issued. 4) This PAC plan is effective immediately and will continue until terminated, which either the account holder or Foresters may do at any time by written notice to the other.

**Agreements**

I, the proposed insured, as evidenced by my signature in this Application, declare that: 1) I have reviewed this Application and provided the answers in this Application. 2) The statements, answers, and representations contained in this Application are full, complete and true.

I understand and agree that: 1) All statements made in this Application shall be representations and not warranties. 2) This Application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently amended shall form part of the entire contract with Foresters. 3) No person, including a producer, has the authority to waive the disclosure of full, complete and truthful information or record an answer to a question in this Application other than the answer provided to that person. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) Failure to disclose all material facts may result in a loss of coverage and cancellation of the insurance contract. A material misrepresentation or untrue declaration may render the insurance contract issued, if any, voidable. All facts should be shown in this Application. 6) The insurance contract issued, if at all, as a result of this Application, will only come into effect, subject to the terms of and on the issue date of that insurance contract, provided that a) the first premium payment is honored by the financial institution from which it is to be drafted, and b) my insurability did not change between the date this Application was signed and that issue date. There is no conditional or temporary insurance coverage in effect.

I further understand and agree that: 1) Changes or corrections made to this Application by Foresters, if any, are ratified 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 one, 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 submitted to Foresters by, including but not limited to, email and facsimile transmission. 4) Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 5) If I have chosen to provide a current internet email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 6) Any person who knowingly and with intent to defraud Foresters, any other insurer, or other person(s), files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

I acknowledge that I have received an Accidental Death Term Insurance Outline of Coverage.

Proposed insured's signature (for purposes of entire application): **X** \_\_\_\_\_

Signed at: \_\_\_\_\_ Signed on: \_\_\_\_\_  
(City, State.) Date (mmm/dd/yyyy)

**Producer Certification**

Unless otherwise indicated in the Remarks section I certify each of the following: I have accurately recorded on this Application the information that was provided to me by the proposed insured. I am not aware of undisclosed information about the health, habits or lifestyle of the proposed insured that might affect insurability. I personally reviewed the document(s) used to verify the proposed insured's identity and birth date. I have complied with all applicable regulatory requirements. I have made no misrepresentation(s) about Foresters product(s) applied for in this Application. If applicable, I have disclosed that this Application may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission. This Application has not been altered in any way after the proposed insured signed it.

I also certify that I have provided the proposed insured with an Accidental Death Term Insurance Outline of Coverage.

Are you related to the proposed insured?  Yes  No If "Yes", indicate relationship: \_\_\_\_\_

Producer's full name: \_\_\_\_\_ Producer number: \_\_\_\_\_

Producer's signature: **X** \_\_\_\_\_ Signed on: \_\_\_\_\_  
Date (mmm/dd/yyyy.)

**Remarks**

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

*Detach and leave with the proposed insured.*

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**Acknowledgement Of First Premium**

It is acknowledged that an amount of \$ \_\_\_\_\_ was provided, by either check or pre-authorized checking, to be applied as the first premium payment for the insurance contract issued, if any, in response to the Application for Accidental Death Term Insurance ("Application") on the life of

\_\_\_\_\_  
Proposed insured's name.

This amount will be refunded, if collected by Foresters™, if no insurance contract is issued. The first premium amount may be adjusted, if required, based on the insurance contract that is issued.

**There is no conditional or temporary insurance coverage** even though an amount was provided, or collected, as the first premium payment.

Insurance will only come into effect on the issue date of the insurance contract issued, if any, and subject to the terms of that insurance contract, provided that a) the first premium payment is honored when presented to the financial institution from which it is to be drafted, and b) the insurability of the proposed insured did not change between the date the Application was signed by the proposed insured and that issue date.

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

Foresters™ is a trademark of The Independent Order of Foresters a fraternal benefit society.

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

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

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

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

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

**THE INDEPENDENT ORDER OF FORESTERS ("Foresters")  
ACCIDENTAL DEATH TERM INSURANCE  
REQUIRED OUTLINE OF COVERAGE**

**ACCIDENT ONLY COVERAGE. Benefits are NOT provided for loss due to sickness.**

For purposes of this form, "I", "you" and "your" mean the owner of the insurance contract that is issued, if any, and "we", "our" and "us" mean Foresters™. "Age" means the insured's issue age plus the number of completed certificate years. "Injury" means an accidental bodily injury that is the direct result of an accident, independent of an illness, disease, condition or bodily infirmity.

**READ YOUR INSURANCE CONTRACT CAREFULLY:** This outline of coverage provides a very brief description of some of the important features of the insurance contract. This is not the insurance contract and only the actual provisions of the insurance contract will control. The insurance contract sets forth in detail the rights and obligations of both you and us. It is, therefore, important that you **READ THE INSURANCE CONTRACT CAREFULLY!**

Accident only coverage is designed to provide the insured with coverage for certain losses due to injury resulting from a covered accident **ONLY**. Coverage is provided for the benefits outlined in the Benefits section (below), subject to the limitations described in the Risks Not Covered section (below). Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

## **Benefits**

### **Certificate Death Benefit**

Subject to the provisions of the entire contract, we will pay the death benefit upon our receipt of proof of the insured's accidental death. Accidental death being death that (a) is caused, directly and independently from all other causes, by an injury that occurs while the certificate is in effect, and (b) occurs within 180 days of that injury.

### **Renewability**

The certificate is noncancellable and guaranteed renewable to age 75 (certificate expiry date). As long as the total premium is paid when due, as described in the certificate, we cannot cancel the coverage provided by the certificate before that age.

**Optional Rider Benefits** (The rider benefits outlined below are only applicable if that rider is attached to the certificate.)

### Return of Premium Rider

Subject to the provisions of the entire contract, we will pay you the rider's benefit amount on the rider payment date if the insured is alive on that date. The rider's benefit amount is determined on the rider payment date and is equal to a percentage, up to 100%, of the eligible premiums paid. The rider's benefit amount is not payable if the insured dies on or before the rider payment date.

### Disability Income Rider (Accident Only)

Subject to the provisions of the entire contract, we will pay you the rider's benefit amount for each completed month of the insured's total disability that follows after completion of the waiting period. Total disability must:

- Be due to an injury that occurs while the rider is in effect.
- Begin while the rider is in effect and within 180 days of that injury.
- Be immediately preceded by a week during which the insured is actively employed for at least 30 hours.
- Be continuous throughout the entire waiting period.

Payment of the benefit amount is limited to a maximum of 24 months each, for two separate and independent injuries.

#### Rider Renewability

The rider is guaranteed renewable to age 65 (rider expiry date). As long as the total premium is paid when due, as described in the certificate, we cannot cancel the coverage provided by the rider before that age. The total premium, up to the rider expiry date, includes the required premium for the rider.

We reserve the right to increase the premiums for the rider, but not more than once in every 12 month period. Each increase will be subject to the approval of the insurance regulator for the state governing the rider, if required. We will send you 45 days notice of the premium increase.

There will be no premium increase because the insured's health worsens or the insured's occupation changes. Each premium increase will be made on a uniform basis that does not discriminate unfairly within a class of lives insured.

### Waiver of Premium Rider (Accident Only)

Subject to the provisions of the entire contract, we will waive the total premium due on a premium due date that the insured is totally disabled. Total disability must:

- Be due to an injury that occurs while the rider is in effect.
- Begin while the rider is in effect and within 180 days of that injury.
- Be continuous for at least 6 months.

If total disability begins prior to the certificate anniversary on which the insured is age 60 and is continuous after that anniversary, then the maximum date that premiums can be waived for that total disability is the certificate anniversary on which the insured is age 75 (certificate expiry date).

If total disability begins on or after the certificate anniversary on which the insured is age 60 and is continuous after that anniversary, then the maximum date that premiums can be waived for that total disability is the certificate anniversary on which the insured is age 65 (rider expiry date).

#### Rider Renewability

The rider is noncancellable and guaranteed renewable to age 65 (rider expiry date). As long as the total premium is paid when due, as described in the certificate, we cannot cancel the coverage provided by the rider before that age. The total premium, up to the rider expiry date, includes the required premium for the rider.

## Risks Not Covered

We will not provide benefits for death or total disability that results directly or indirectly from any of the following:

- Attempted suicide or intentionally self-inflicted injuries, while sane or insane.
- Voluntary participation in a riot or civil commotion.
- Committing or attempting to commit a felony.
- Involvement in an illegal occupation.
- War or act of war, whether declared or undeclared.
- Exposure to abnormal hazards because of service in the armed forces of any country or association of countries, whether war is declared or not and whether on active duty or not.
- Aviation, of any form, unless as a fare paying passenger in a fully licensed passenger carrying aircraft.
- Mountaineering, climbing, scuba diving or participation in a motor sport.
- Sky diving, gliding, parachuting, ultra-lighting, parasailing or bungee jumping.
- Disease or infirmity, of mind or body, or medical or surgical treatment therefore.
- Infection, other than septic infection occurring through and at the time of accidental cut or wound.
- Stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, or aneurysm, even if the proximate or precipitating cause is an injury.
- The intentional administration, injection, or taking of a drug, hypnotic or narcotic, unless administered on the advice of a physician or, in the case of a legal, non-prescribed drug, as recommended by the drug manufacturer.
- Injury sustained in a motorized vehicle accident if the insured was the operator of the motorized vehicle and one or more of the following exists:
  - A test or report completed by or at the direction of a coroner, law enforcement, government agency or representative, based on a sampling obtained from the body of the insured within 24 hours of the accident, indicates the presence of either or both of the following:
    1. A narcotic in the body of the insured, regardless of the measurement or quantity.
    2. A concentration of alcohol in the insured's blood in excess of the quantity specified in the applicable legislation as an offense for the operation of that type of motorized vehicle.
  - A coroner, law enforcement or government report indicates that, as a result of testing, it was determined that the insured was operating the motorized vehicle while impaired, intoxicated or under the influence of alcohol or an intoxicant, above the legal limit, or a narcotic.

A narcotic does not include a drug that was consumed by the insured at the frequency and dosage instructed or prescribed by a licensed physician or, in the case of a legal, non-prescribed drug, as recommended by the drug manufacturer.

## Premiums

The premiums shown below are based upon the coverage amounts applied for in the application.

	\$ Amount based on a _____ payment mode.	\$ Amount based on an <u>annual</u> payment mode.
Certificate		
Certificate Fee		
Disability Income Rider (Accident Only)		
Waiver of Premium Rider (Accident Only)		
Return of Premium Rider		
Total Premium		

Subject to the grace period, total premiums must be paid when due in order to ensure that coverage remains in effect until the expiry date. A grace period of 31 days is allowed for premiums not paid when due.