

# The Independent Order of Foresters ("Foresters")

## A Fraternal Benefit Society.

789 Don Mills Road, Toronto, ON, Canada M3C 1T9

F. 877 329 4631

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

T. 800 828 1540

foresters.com

Foresters  
Financial

## Tips for Submitting a Foresters Application for Individual Life Insurance - Foresters PlanRight

This Checklist is a quick guide to help avoid processing delays. For more information on completing the Application, please refer to the *PlanRight Product Guide*, available on ezbiz Foresters Financial™ producer website. If you have questions about Foresters, Foresters PlanRight product, Foresters PlanRight Application process, or if you have trouble initiating the required personal health interview (PHI) with Apptical Corp. ("Apptical"), contact Foresters Sales Desk at 1-866-466-7166 option 1, Monday through Friday 8:30 a.m to 7:00 p.m. ET.

### Things You Need To Know

- Money orders, cashier's checks, or cash are not acceptable methods for the payment of premiums. A producer cannot make premium payments (unless the proposed insured is the producer or a dependent of the producer).
- Do not use white out (liquid paper/correction fluid) on any part of the Application.
- A personal health interview (PHI) must be completed with the proposed insured at the time the Application is taken in order for the Application to be processed. Conduct the PHI as soon as your client signs the application, and while you are still with the proposed insured.
- Completion of the PHI must take place at the point of sale and during Apptical's hours of operation, 8:30 a.m. to 2:00 a.m. ET, Monday through Friday and 10:00 a.m. to 10:00 p.m. ET, Saturday and Sunday. To call Apptical, dial 1-866-844-9276.
- In ALL cases where a PHI has been initiated, the signed Application must be submitted to Foresters and the Notices page given to the proposed insured, regardless of whether or not the Application is to be processed. Foresters is required to retain the signed Application as it contains the authorization used to complete the PHI. If the Application is not to be processed, write 'Withdrawn' on the Producer Report and send the Application to Foresters; no premium should be accepted and the Acknowledgement of First Premium should not be left with the owner.
- For instructions on conducting a PHI, refer to the *PlanRight Product Guide*, available on ezbiz.
- The certificate's issue date is the date that Foresters approves the Application, unless a preferred draft date is requested.

### How To Avoid Delays

- Are you contracted with Foresters? You must provide your producer number to Apptical in order to proceed with the PHI.
- Do you have the right Application and forms for the state where the application is signed? Did you verify the product rules and state availability for the applicable state?
- Did you print legibly in English, using ink (preferably black)?
- If the payer is other than the proposed insured or the owner, did you complete a Contingent Owner/Other Payer Identification form and include it with the Application?
- If Pre-Authorized Checking (PAC) has been requested, did you complete the Payment Information section in full? Did you explain PAC to the payer and are they fully aware that the PAC authorization is effective immediately?
- When choosing a preferred draft date did you select either the day of the month (between the 1<sup>st</sup> and the 28<sup>th</sup>) or the day of the week (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> or 4<sup>th</sup> Monday to Friday of the month)?
- If replacing existing insurance or an annuity, did you complete the applicable replacement form(s) and include them with the Application?
- If there were changes, did you, the proposed insured and the owner, if other than the proposed insured, initial ALL corrections before signing the Application?
- Is the Application dated the same day as the Apptical interview?
- Are all sections of the Application signed, including:
  - Signature Section signed by the proposed insured and the owner, if other than the proposed insured.
  - Producer Certification signed by the producer.
  - Acknowledgement of First Premium signed by the producer.
- Did you leave the following pages from the Application Package?
  - Notices page with the proposed insured.
  - Acknowledgement of First Premium with the owner.
  - Accelerated Death Benefit Rider (for Terminal Illness) Disclosure with the owner.
- Did you record the Inspection Reference ID number provided by Apptical on the Producer Report? We can't proceed without it.
- If you'd like to save insurance age, did you indicate this on the Producer Report?
- If paying the first premium by check, did the payer make the check payable to Foresters? The check must be dated no later than the date the Application was signed by the owner.
- If mailing the Application and a check was provided, did you mail the Application and the check together?
- If submitting the Application by fax, Foresters fax number is 1-866-300-3830. When faxing, did you include a photocopy of the void check?

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For Producer Only. Not For Use With The General Public.

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## Application for Individual Life Insurance

1. Proposed Insured (full legal name)				
First name	Middle name	Last name	<input type="radio"/> Male <input type="radio"/> Female	
Street address	City	State	Zip	
Social security #	Home phone #	Alternate phone/Cell #	Date of birth (mmm/dd/yyyy)	State & Country of birth
U.S. Citizen? <input type="radio"/> Yes <input type="radio"/> No. If "No" then immigration status: <input type="radio"/> Permanent Resident (Green Card) <input type="radio"/> Other (provide visa type): _____				
Type of photo I.D. used to verify identity: <input type="radio"/> Driver's license <input type="radio"/> Passport <input type="radio"/> Other government I.D.: _____				
Foresters member? <input type="radio"/> Yes <input type="radio"/> No, applying for membership.		E-mail		
Height (ft/in) / Weight (lbs) /	Within the past 12 months, has the Proposed Insured used tobacco or nicotine in any form? <input type="radio"/> Yes <input type="radio"/> No			

## 2. Medical Questions (For purposes of these questions "you" and "your" mean the proposed insured, "diagnosed", "advised", "tested", "referred", "repaired", "monitored", "observed", "treated" and "treatment" mean by a licensed physician or medical practitioner and "terminal illness" means an illness that would reasonably be expected to cause death within 12 months.)

If a "Yes" answer to questions 1-6, the proposed insured is not eligible for Foresters PlanRight. Do not complete or submit this application.

- Are you:
  - A resident in, or have you been advised to move into, a nursing home or skilled nursing facility?  Yes  No
  - Receiving, or have you been advised to receive, skilled nursing care, hospice care, or home healthcare?  Yes  No
  - A patient in a hospital or psychiatric facility, or confined to a correctional facility?  Yes  No
  - Using a wheelchair or electric scooter due to an ongoing illness, medical condition, or disease?  Yes  No
  - Requiring help (from anyone) with administering or taking your medications, or with bathing, dressing, eating, or toileting?  Yes  No
- Within the past year (12 months), have you been advised to:
  - Use, or have you used, oxygen equipment to assist with breathing (excluding use for sleep apnea)?  Yes  No
  - Have, or have you had, kidney dialysis?  Yes  No
  - Have surgery, a medical procedure, hospitalization, or have you been referred for a check up or consultation with a doctor or medical specialist, which has not yet been started, completed, or for which results are not known?  Yes  No
  - Have a diagnostic test, or have you been referred to get a lab test, which has not yet been started, completed, or for which results are not known (excluding tests related to the Human Immunodeficiency Virus (HIV))?  Yes  No
- Within the past year (12 months), have you consulted a physician for, been diagnosed with, or received or been advised to receive treatment or medication for, unexplained weight loss greater than 10 pounds?  Yes  No
- Have you ever:
  - Received, or been advised to receive, an organ or bone marrow transplant, or had an amputation due to complications of diabetes?  Yes  No
  - Tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?  Yes  No
- Have you ever been diagnosed with, or received or been advised to receive treatment or medication for:
  - Cardiomyopathy, Congestive Heart Failure (CHF), Pulmonary Hypertension, or any other type of heart failure or heart muscle disease?  Yes  No
  - Amyotrophic Lateral Sclerosis (ALS), or a terminal illness or end-stage disease?  Yes  No
  - Alzheimer's disease, dementia, or memory loss?  Yes  No
- Have you ever been diagnosed with more than one occurrence of the same or different type of cancer, or do you currently have cancer (the term "cancer" excludes basal cell skin cancer)?  Yes  No

If all "No" answers to questions 1-6, then continue with questions 7-12.

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Complete questions 7-12 and indicate (e.g. circle or underline) the condition(s) to which each "Yes" answer, if any, applies.

7. Have you ever been diagnosed with diabetes and have also been diagnosed with, or advised to receive treatment for:
- a) Retinopathy (problems with your eyesight)? \_\_\_\_\_  Yes  No
  - b) Nephropathy (kidney disease or kidney damage)? \_\_\_\_\_  Yes  No
  - c) Peripheral Neuropathy (nerve damage or numbness)? \_\_\_\_\_  Yes  No
8. Within the past 2 years (24 months), have you been hospitalized for 48 hours or more due to diabetes? \_\_\_\_\_  Yes  No
9. Within the past 2 years (24 months), have you been diagnosed with, or received or been advised to receive treatment for:
- a) Alcohol or drug abuse, or have you used illegal drugs? \_\_\_\_\_  Yes  No
  - b) An aneurysm, or have you ever been diagnosed with an aneurysm that has not yet been repaired? \_\_\_\_\_  Yes  No
  - c) A brain tumor, or have you ever been diagnosed with a brain tumor that has not yet been treated or is being monitored or observed? \_\_\_\_\_  Yes  No
10. Within the past year (12 months), have you been diagnosed with having:
- a) A heart attack, stroke, or Transient Ischemic Attack (TIA/mini-stroke)? \_\_\_\_\_  Yes  No
  - b) Angina, or have you taken medication for angina? \_\_\_\_\_  Yes  No
11. Within the past year (12 months), have you been advised to have, or have you had, a pacemaker or defibrillator implant, cardioversion treatment, or any other type of heart or circulatory procedure? \_\_\_\_\_  Yes  No
12. Within the past 3 years (36 months), have you been diagnosed with cancer, or received or been advised to receive chemotherapy, radiation, or any other type of treatment for cancer (the term "cancer" excludes basal cell skin cancer)? \_\_\_\_\_  Yes  No

If a "Yes" answer in questions 7-12, then apply for Foresters PlanRight (Basic). If all "No" answers then continue with questions 13-15.

Complete questions 13-15 and indicate (e.g. circle or underline) the condition(s) to which each "Yes" answer, if any, applies.

13. Have you ever been diagnosed with, or received or been advised to receive treatment or medication for:
- a) Parkinson's disease or Systemic Lupus (SLE)? \_\_\_\_\_  Yes  No
  - b) Hepatitis B or C, cirrhosis of the liver, or any other type of liver disease or condition? \_\_\_\_\_  Yes  No
  - c) Chronic kidney disease, chronic renal insufficiency, or any other type of kidney disease or condition (excluding kidney stones)? \_\_\_\_\_  Yes  No
  - d) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, or any other type of chronic lung disease or ongoing respiratory condition (excluding asthma or sleep apnea)? \_\_\_\_\_  Yes  No
14. Within the past 2 years (24 months), have you been diagnosed with having:
- a) A heart attack, stroke, or Transient Ischemic Attack (TIA/mini-stroke)? \_\_\_\_\_  Yes  No
  - b) Angina, or have you taken medication for angina? \_\_\_\_\_  Yes  No
15. Within the past 2 years (24 months), have you been advised to have, or have you had, a pacemaker or defibrillator implant, cardioversion treatment, or any other type of heart or circulatory procedure? \_\_\_\_\_  Yes  No

If a "Yes" answer in questions 13-15, then apply for Foresters PlanRight (Standard).

If all medical questions 1-15 are answered "No", then apply for Foresters PlanRight (Preferred).

### 3. Insurance Applied For

#### Certificate type (based on answers to Section 2 Medical Questions)

If there is a "Yes" answer to questions 1-6, do not complete or submit this application.

If there is a "Yes" answer to questions 7-12, then you are applying for Foresters PlanRight:  Basic (graded death benefit)

If there is a "Yes" answer to questions 13-15, then you are applying for Foresters PlanRight:  Standard (level death benefit)

If all medical questions are answered "No" then you are applying for Foresters PlanRight:  Preferred (level death benefit)

Insurance amount: \$ \_\_\_\_\_ Additional coverage: (only available if applying for Foresters PlanRight (Preferred)

Accidental Death Rider \$ \_\_\_\_\_ (benefit amount)

Premium amount: \$ \_\_\_\_\_ (based on payment mode, including premium for Accidental Death Rider, if applied for)

**Automatic selection, insurance amount and premium adjustment** – Owner agrees that if: (i) applying but not qualifying for, based on the information in this application, Foresters PlanRight (Preferred) the owner is instead automatically applying in this application for Foresters PlanRight (Standard); (ii) applying as per (i) above but not qualifying for, based on the information in this application, Foresters PlanRight (Standard), the owner is instead automatically applying in this application for Foresters PlanRight (Basic); (iii) the proposed insured qualifies for the certificate applied for above but the premium amount paid with this application is not sufficient for the insurance amount shown above, Foresters shall issue that certificate type for a reduced insurance amount based on the above, or modified if necessary according to the applicable rates, premium amount for that reduced insurance amount. If the premium amount shown above is more or less than the amount required for the certificate type issued, Foresters will increase or decrease the insurance amount and/or premium for that certificate.

#### 4. Automatic Premium Loan

Automatic premium loan provision elected? \_\_\_\_\_  Yes  No

If "Yes", overdue premium will be paid through a loan against, and for as long as there is, available cash value, if any.

If "No", or if an election is not made, the certificate's Nonforfeiture provisions will automatically apply, if premium is overdue at the end of the Grace Period.

#### 5. Payment Information

Payer is:  Proposed insured  Owner (if other than proposed insured)  Other (Complete Contingent Owner/Other Payer I.D. Form)

First premium payment provided by:  Pre-Authorized Check (PAC)  Check

Subsequent premium payments made by:  Pre-Authorized Check (PAC)  Direct bill

Payment mode (select one):  Monthly (PAC only)  Quarterly  Semi-annually  Annually

Requesting a specific draft day?

- No (draft first premium payment immediately upon Foresters application approval)
- Yes (choose option below)
  - Draft on the \_\_\_\_\_ day (choose between 1<sup>st</sup> and 28<sup>th</sup>) of the month.
  - Draft on the \_\_\_\_\_ (choose 1<sup>st</sup> to 4<sup>th</sup>) \_\_\_\_\_ (choose Monday to Friday) of the month

For PAC, I understand premiums will be drafted on the day I requested, with the exception of the initial premium which may occur on a day other than specified on this application. If no day was requested, the premium will be drafted in accordance with the certificate issue date.

**PAC Banking information to be taken from:**

Void check (attach here)  Information completed below (if no check available)  Check submitted with the application

Type of Account:  Checking  Savings

Name of financial institution: \_\_\_\_\_

Routing Transit # (9 digits): \_\_\_\_\_

Account # (maximum 17 digits): \_\_\_\_\_

#### PAC Authorization

The payer, by signing below, verifies that the payer is the account holder of the account identified in the PAC banking information section (above) and is permitted to provide this authorization, and agrees that: 1) Foresters is authorized to electronically draft deductions, for premiums and/or other payments related to an insurance contract issued, if any, as a result of this application, from that account or another account later identified or substituted by, or on behalf of, the payer, such as for additional coverage, loan repayment(s) or for premium deposit funds. 2) The financial institution from which deductions are to be drafted is authorized to treat each draft by Foresters as though it was made personally by the payer. 3) Foresters reserves the right to determine when the first deduction and each subsequent deduction, if any, will be made and the amount of each deduction. Subsequent deduction amounts may vary. 4) If a deduction request is not honored when submitted to the financial institution Foresters may, at its sole discretion, do further resubmits for the deduction. 5) This authorization is effective immediately and will continue until terminated, which either the payer or Foresters may do at any time by written notice to the other.

This authorization must be signed by the account holder as his/her name appears on banking records for the account provided. If the account provided is a joint account that requires two signatures, then both account holders must sign.

\_\_\_\_\_ **X** \_\_\_\_\_  
 Print Name of Payer / Print Name of joint account holder (if required)      Signature of Payer / Signature of joint account holder (if required)

**Conversion Notification:** Foresters can process a check provided for payment as a check transaction or instead take the information from the check to make a one-time electronic fund transfer from the account that the check relates to.

## 6. Other Insurance and Financial Questions

Does the proposed insured currently have any life insurance or an annuity in force? \_\_\_\_\_  Yes  No

Will insurance applied for in this application replace, reduce coverage or modify premiums paid for any existing life insurance or an annuity in force? \_\_\_\_\_  Yes  No

Is there currently an intention that a person or entity, other than the owner, will obtain a right, title, or interest in a certificate issued (including possible assignment)? \_\_\_\_\_  Yes  No

## 7. Owner (Complete only if other than the proposed insured.)

Full legal name of Individual (First, Middle, Last), Institution, or Trust		Social security/Tax ID #	
Street address		City	State Zip
Type of photo I.D. used to verify identity: <input type="radio"/> Driver's license <input type="radio"/> Passport <input type="radio"/> Other government I.D.: _____			
Relationship to proposed insured		E-mail	Phone #
If Trust:	Name of Trustee	Date of Trust agreement	
If Individual:	<input type="radio"/> Male <input type="radio"/> Female	Date of birth (mmm/dd/yyyy):	U.S. Citizen? <input type="radio"/> Yes <input type="radio"/> No. If "No" then immigration status: <input type="radio"/> Permanent Resident (Green Card) <input type="radio"/> Other (provide visa type): _____

## 8. Secondary Addressee (Optional. To designate another person to receive notification of a past due payment and a possible lapse in coverage.)

Name (First, Middle, Last)		<input type="radio"/> Male <input type="radio"/> Female	
Street address		City	State Zip

## 9. Beneficiary Information (Each beneficiary below is revocable, unless "irrevocable" is written next to the name of that beneficiary.)

Primary	Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	% Share
Name: Address:			The
Name: Address:			total
Name: Address:			must
Name: Address:			equal
Name: Address:			100%
Contingent	Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	% Share
Name: Address:			The total
Name: Address:			must equal
Name: Address:			100%

## 10. Additional Information

Is the proposed insured taking dual use medication? \_\_\_\_\_  Yes  No

If "Yes", list each dual use medication and the reason it was prescribed: \_\_\_\_\_



## 11. Agreements

I, the proposed insured and/or owner, declare that I have reviewed all of the statements and answers as they pertain to me and that they are true and complete to the best of my knowledge and belief. The statements and answers in this application are the basis for an insurance contract (defined as a certificate and each rider attached to that certificate), if any, issued by Foresters. No information about me will be considered to have been given to Foresters by me unless it is stated in this application. A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may, subject to the Incontestability provision, result in loss of coverage or cancellation of the insurance contract. No agent/producer, medical examiner, or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to make, modify, or discharge an insurance contract. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. Foresters will have no liability under an insurance contract issued based on this application until the date that insurance contract comes into effect, according to its terms and then only if the first premium due is provided in full on or before the delivery date of that insurance contract, and provided that there has been no change in either an answer to an application question or the proposed insured's health or habits between the date this application was signed and the issue date of that insurance contract. Changes or corrections made to this application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. This application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently enacted, shall form part of the entire contract with Foresters. This application and related documents may be sent by electronic means. 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. If I have chosen to provide an email address in this application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. Foresters may review, transfer and otherwise use, information provided in this application to offer and issue (including post issue administration), other insurance products to me. Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identification. If I am the owner and if the life insurance applied for has a level death benefit, I have been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

## 12. Authorization To Obtain And Disclose Information

"Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product or benefit claim. For purposes of assessing insurance coverage eligibility, coverage continuation and/or benefit claim, I, the proposed insured, authorize The Independent Order of Foresters ("Foresters") and its authorized persons, to obtain information, including previously restricted information, about me from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan, other insurer or institution; consumer reporting agency; public records, pharmacy, pharmacy benefits manager, or other pharmacy related services organization; or MIB, Inc. This includes records or other information as to past, current, or future: diagnosis, treatment and prognosis of a physical or mental condition, drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. I, the proposed insured, authorize Foresters and its authorized persons, to make a brief report of my personal and/or protected health information to MIB, Inc. Information may be disclosed: between and among Foresters and its authorized persons; companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this application. A copy of this authorization shall be as valid as the original. This authorization may be revoked at any time by written notice to Foresters, except that reporting to MIB, Inc. and action(s) taken before receipt of notice will not be affected. A copy of this authorization will be provided upon request. I have been provided the Notices.

## 13. Signature Section (For purposes of sections 1 to 12. Review entire Application before signing.)

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

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Proposed Insured's signature Owner's signature (if other than the Proposed Insured)

The owner, or the proposed insured, if the proposed insured is the owner, signed in: \_\_\_\_\_ on: \_\_\_\_\_  
 State Date (mmm/dd/yyyy)

## 14. Agent/Producer Certification

I certify the following: I am not aware of undisclosed information about the health, habits, or lifestyle of the proposed insured that might affect insurability. I complied with applicable regulatory requirements including those relating to the solicitation and sale of life insurance to active duty members of the United States military. All questions, to which an answer is shown, were asked as written in this application. The answers given by the proposed insured or owner were recorded as shown and this application was reviewed with the proposed insured and owner before it was signed. If the life insurance applied for has a level death benefit, the owner has been provided, either in paper or electronically, with the Accelerated Death Benefit Disclosure.

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

Agent/Producer's full name: \_\_\_\_\_ Agent/Producer's signature: **X** \_\_\_\_\_

Agent/Producer number: \_\_\_\_\_ Date (mmm/dd/yyyy): \_\_\_\_\_

Florida license identification #: \_\_\_\_\_

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### Notices (this section must be given to the proposed insured)

For purposes of this Notice the following words and phrases are defined: "Application" means the Application for Individual Life Insurance to which this Notice relates; "Foresters", "we", "our", and "us" mean The Independent Order of Foresters; "Authorized persons" means reinsurers, insurance agents, agencies, and Foresters subsidiaries and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business analysis and operations; "Producer" means the licensed individual who signed the Application as the producer; "You" and "Your" mean the proposed insured identified in the Application. If you have questions regarding your application, discuss them with your producer or contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. Box 179 Buffalo, NY 14201-0179.

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

**Medical and Personal Information** - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. We may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include personal characteristics such as health and prescription history. 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. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for AIDS information.

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

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### Acknowledgement of First Premium (this section must be given to the owner)

It is acknowledged that an amount of \$ \_\_\_\_\_ was provided or authorized to be collected, to be applied as the first premium payment for the certificate issued, if any, in response to the Application for Individual Life insurance on the life of \_\_\_\_\_ Proposed insured's name.

This amount will be refunded, if collected by us, if no certificate is issued. The first premium amount may be adjusted based on the certificate type 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 certificate issued, if any, and subject to the terms of that certificate, provided a) that first premium payment is honored when presented to the financial institution from which it is to be collected, and b) that there has been no change in either an answer to an application question or the proposed insured's health or habits between the date the application was signed and the issue date of that insurance contract.

Producer's signature: **X** \_\_\_\_\_

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

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

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### Accelerated Death Benefit Rider (for Terminal Illness) Disclosure

(This disclosure must be given to the owner, only if the life insurance applied for has a level death benefit.)

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

#### Benefit Description

The rider provides the opportunity for the owner to accelerate a portion of the certificate's eligible death benefit ("acceleration amount"), during the lifetime of the insured, and receive an accelerated death benefit payment ("payment"). Under the conditions described in the rider the owner may elect to receive a payment if the insured is diagnosed, by a physician, with a terminal illness. Terminal illness means the insured has a non-correctable illness or physical condition which is reasonably expected to result in death within 12 months of diagnosis. The payment is paid to the owner and not to the beneficiary(ies). A claim made during the contestable period may result in cancellation of the insurance contract, with no benefit being paid. The rider is not, and is not intended to be, long-term care insurance.

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

#### Amount of the Accelerated Death Benefit Payment

The accelerated death benefit payment may be less than the acceleration amount as we may deduct from the acceleration amount the sum of the unpaid total premium and a loan repayment amount, if there is an outstanding loan.

The acceleration amount must be at least \$2,000.00 and must be such that after acceleration a residual face amount of at least \$2,000.00 remains. The maximum amount that can be accelerated is the lesser of 95% of the eligible death benefit on the effective date of the payment and \$35,000.

#### Effect of Payment on the Certificate

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

#### Effect of Payment on Taxation and Eligibility for Public Assistance

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

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

#### Example of an Accelerated Death Benefit Payment

The following example is hypothetical and is intended only to demonstrate an accelerated death benefit payment and to show the relationship between certificate values before and after payment of an accelerated death benefit. This example is based upon a whole life insurance certificate, issued when the insured was age 50, with the maximum acceleration amount being accelerated. The amounts, including the accelerated death benefit payment, shown are based upon hypothetical certificate values at the time of acceleration and are not guaranteed. Actual amounts will vary and may be higher or lower.

#### Accelerated Death Benefit Payment Calculation

<b>Acceleration Amount:</b>	<u>\$ 33,000.00</u>
<b>Payment Percentage:</b>	<u>100.00%</u>
<b>Gross Payment Amount:</b>	<u>\$ 33,000.00</u>
minus <b>Loan Repayment:</b>	<u>\$ 1,885.00</u>
minus <b>Overdue Premium(s):</b>	<u>\$ 0.00</u>
<b>Accelerated Death Benefit Payment:</b>	<u>\$ 31,115.00</u>

#### Effect on Certificate Values

	<u>Before Acceleration</u>	<u>After Acceleration</u>
<b>Face Amount:</b>	<u>\$ 35,000.00</u>	<u>\$ 2,000.00</u>
<b>Amount of Paid-up Additional Insurance:</b>	<u>\$ 0.00</u>	<u>\$ 0.00</u>
<b>Eligible Death Benefit:</b>	<u>\$ 35,000.00</u>	<u>\$ 2,000.00</u>
<b>Cash Value:</b>	<u>\$ 4,325.00</u>	<u>\$ 247.00</u>
<b>Cash Value of Paid-up Additional Insurance:</b>	<u>\$ 0.00</u>	<u>\$ 0.00</u>
<b>Loan Amount:</b>	<u>\$ 2,000.00</u>	<u>\$ 115.00</u>
<b>Cash Surrender Value:</b>	<u>\$ 2,325.00</u>	<u>\$ 132.00</u>
<b>Annual Premium:</b>	<u>\$ 952.00</u>	<u>\$ 88.35</u>

Foresters™ is the trade name and a trademark of The Independent Order of Foresters ("Foresters").



# The Independent Order of Foresters ("Foresters")

## A Fraternal Benefit Society.

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### PlanRight Producer Report (Required)

This form is for internal and producer use only and is not part of the application

#### Producer:

Producer Name: \_\_\_\_\_ Producer Number: \_\_\_\_\_

#### Proposed insured:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of birth (mmm/dd/yyyy): \_\_\_\_\_

1. How long have you known the proposed insured? \_\_\_\_\_ Years
2. Are you related to the proposed insured? \_\_\_\_\_  Yes  No  
If 'Yes', what is the relationship?: \_\_\_\_\_
3. At the time the application was taken, did you:
  - a) See the proposed insured? \_\_\_\_\_  Yes  No
  - b) Personally interview and complete the application in the presence of the proposed insured? \_\_\_\_\_  Yes  NoIf 'No' to either a or b, explain in Remarks below.
4. Did you personally witness each signature in the application? \_\_\_\_\_  Yes  No  
If 'No', identify and provide contact information of the person who obtained and witnessed the signature(s).  
\_\_\_\_\_
5. Did you personally review each document used to verify identity and birth date? \_\_\_\_\_  Yes  No  
If 'No', identify and provide contact information of the person who reviewed each document (if different than the person identified in question 4.).  
\_\_\_\_\_
6. A personal health interview (PHI) must be conducted as part of the application process. Provide the PHI Inspection Reference ID number. # \_\_\_\_\_
7. Upon completion of the PHI, did the interviewer confirm eligibility for the certificate type selected? \_\_\_\_\_  Yes  No  
If 'No', were changes to the application made and initialed, and a new page 5 signed, in both sections 13 & 14, as required? \_\_\_\_\_  Yes  No
8. Did you review and leave the Acknowledgement of First Premium with the owner? \_\_\_\_\_  Yes  No
9. Proposed insured's primary language is:  English  Spanish  Other \_\_\_\_\_
10. Number of people under 25 years of age living in the proposed insured's household? \_\_\_\_\_
11. Was a copy of the Buyer's Guide provided to the owner at the time of sale? \_\_\_\_\_  Yes  No
12. Are the commissions to be split with another producer? \_\_\_\_\_  Yes  No  
If 'Yes', state what the percentage should be for the producer who filled out the application: \_\_\_\_\_ %  
Name and producer number of producer who will receive the remaining percentage: \_\_\_\_\_

**Note: If the proposed insured has had life insurance with Foresters that was in force but has lapsed or been surrendered within the last 13 months, then the application will be considered an internal replacement and will affect compensation.**

#### Certificate Issuing Instructions

Should the certificate's issue date be adjusted to save the insurance age? (if yes, additional premium may be required) \_\_\_\_\_  Yes  No

The certificate should be:  Mailed directly to the owner.  Sent to producer for delivery.

#### Remarks


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**IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

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

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

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

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

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

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

YES

NO

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

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

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRODUCER'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRODUCER'S NAME (PRINTED OR TYPED)

\_\_\_\_\_  
PRODUCER'S ADDRESS (PRINTED OR TYPED)

\_\_\_\_\_  
PRODUCER'S COMPANY (PRINTED OR TYPED)

Information on Policies or Contracts which may be replaced:

<u>Company Name</u>	<u>Policy or Contract Number</u>	<u>Name of Insured</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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YES

NO

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

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRODUCER'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRODUCER'S NAME (PRINTED OR TYPED)

\_\_\_\_\_  
PRODUCER'S ADDRESS (PRINTED OR TYPED)

\_\_\_\_\_  
PRODUCER'S COMPANY (PRINTED OR TYPED)

Information on Policies or Contracts which may be replaced:

<u>Company Name</u>	<u>Policy or Contract Number</u>	<u>Name of Insured</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

### CERTIFICATE DISCLOSURE FORM AND INSTRUCTIONS

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

**PART A - CURRENT CERTIFICATE INFORMATION**     LIFE     ANNUITY

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

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

**PART B - PROPOSED CERTIFICATE INFORMATION**     LIFE     ANNUITY

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

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

**PART C - SOURCE OF FUNDING FOR THE PROPOSED CERTIFICATE**

- A loan in the amount of \$ \_\_\_\_\_ will be taken from the value of your CURRENT CERTIFICATE, each \_\_\_\_\_ (mode), bearing a current loan interest rate of \_\_\_\_\_%.
- A partial surrender in the amount of \$ \_\_\_\_\_ will be taken from the value of your CURRENT CERTIFICATE, each \_\_\_\_\_ (mode).
- A dividend withdrawal in the amount of \$ \_\_\_\_\_ will be taken from the value of your CURRENT CERTIFICATE, each \_\_\_\_\_ (mode).

**PART D - YOUR CURRENT CERTIFICATE COULD TERMINATE**

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

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

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

Certificate Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Producer/Agent or Company Officer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Florida Licensed Producer/Agent Number or Corporate Title \_\_\_\_\_

Complete three copies of page 1. Leave one copy of page 1 & 2 with the Owner, submit one copy of page 1 to Foresters, and keep one copy of page 1 for your records.

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

Any and all information applicable to the transaction shall be fully and completely disclosed on the Certificate Disclosure form. If the information requested does not apply to the transaction, the words "not applicable" or "N/A" shall be entered.

**PART A**

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

**PART B**

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

**PART C**

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

**PART D**

The information to be disclosed in Part D of the Certificate Disclosure form shall apply to the current, in-force certificate and the proposed additional certificate, respectively.

**SIGNATURES**

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



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**Consent for Electronic Delivery of Insurance Contract and Related Documents**

(‘you’ and ‘your’ means the Owner identified below)

If an insurance contract is approved by Foresters™, to expedite delivery of that contract, we are providing you with the option to receive, by secure email, your Foresters Welcome Package, that includes your insurance contract and may also include additional document(s) for your review, signature and return to Foresters (collectively “Applicable Documents”).

These documents will be in PDF format which will require Adobe Reader to open. If you do not have that software, the free version can be downloaded from: <https://get.adobe.com/reader/otherversions/>.

The email will show up in your e-mail inbox as sent from [contractdeliveries@foresters.com](mailto:contractdeliveries@foresters.com).

By selecting the “I Accept Electronic Delivery” option below, you are providing your consent to receive the Applicable Documents by secure email, at the email address shown below, instead of receiving in paper. You are also confirming that it is your email address. Please ensure you provide your own valid email address below.

If you choose “I Decline Electronic Delivery”, a paper copy of your Welcome Package will be mailed directly to the Owner or delivered by the producer who assisted with this application.

I Accept Electronic Delivery and confirm the email address below is mine.

My email address is: \_\_\_\_\_.

I Decline Electronic Delivery.

\_\_\_\_\_  
Print Owner Name

\_\_\_\_\_  
Owner Signature

\_\_\_\_\_  
Date Signed (MMM/DD/YYYY)

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**COVID-19 (Coronavirus) Questionnaire**

<b>Proposed Insured</b>	
First name _____	Middle name _____ Last name _____
Date of Birth _____ (mmm/dd/yyyy)	Reference/certificate number (if available): _____

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured. "Advised", "diagnosed", "medical advice", "tested", "treated" and "treatment" mean by a licensed physician or medical practitioner.

1. Within the past 14 days, have you been diagnosed with, or been treated or given medical advice for any of the following?

- Yes: *(check all that apply)*
  - Fever
  - Flu-like fatigue
  - Loss of smell or taste
  - Nausea, vomiting and/or diarrhea
- Persistent cough that has not subsided
- Shortness of breath
- Sore throat
- No

2. Within the past 30 days, have you been diagnosed with, tested positive for, or been advised to take a test for, that has not yet been started or completed or the results of which are not yet known for, COVID-19 (Coronavirus)?

- Yes
- No

3. Within the past 30 days, has a parent or sibling living in your household been diagnosed with or been treated for COVID-19 (Coronavirus)? *If "Yes", please provide details.*

- Yes
- No

Details: \_\_\_\_\_

4. Within the past 21 days have you returned from travel outside the United States? *If "Yes", please advise as to the country travelled to and the date of return to the United States.*

- Yes: Country: \_\_\_\_\_ Date returned to the United States: \_\_\_\_\_
- No

5. Within the past 30 days, have you been advised to self-isolate or be quarantined, due to symptoms of, or for any other reason related to, COVID-19 (Coronavirus)?

- Yes
- No

I declare that I have reviewed this COVID-19 (Coronavirus) Questionnaire and represent that the information provided in this questionnaire, is true and is a complete disclosure of all information requested in this questionnaire, to the best of my knowledge and belief. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

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

**X** \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

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