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

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Document Name	**Description**	**Expiration Date**
770845-ny-0620	Application for individual life insurance	12/31/2199
105349_NY	Illustration Certification	12/31/2199
105273_NY	Compensation Disclosure Statement	12/31/2199
105003_NY	Appendix 10C - Important Notice Regarding Rep...	12/31/2199
105004_NY	Appendix 10A - Disclosure Statement	12/31/2199
105006_NY	Appendix 11 - Definition of Replacement	12/31/2199
105007_NY	Authorization and Direction to Release Life I...	12/31/2199
105922_NY	If there is an intention to replace long-term...	12/31/2199
100964_NY	Notice and Consent for Blood or Urine Testing...	12/31/2199
105690_US_b	1035 Exchange/Absolute Assignment Form	12/31/2199
106075-ny-0320	Suitability Form	12/31/2199
106077-ny-0120	Suitability Additional Information and Waiver	12/31/2199

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

- Money orders or cashier's checks are NOT permitted for the payment of initial premiums.
- Premium payments CANNOT be made by the producer (unless the proposed insured is the producer or a dependent of the producer).
- Explain to your client that if a premium is returned due to non sufficient funds, the bank could attempt to re-draft within 5 business days in order to try to successfully collect the premium.
- Make sure you have the right application and forms for the state where the application is signed. Make sure you verify product rules and state availability for the applicable state.
- We may require additional information for each "Yes" answer to a question in the Lifestyle, either Medical, or a Rider section. You can speed up the Underwriting process by completing the questionnaire that is applicable to each "Yes" answer or if an applicable questionnaire is not available by providing details in the Additional Information section. Available questionnaires are listed on the Producer Report.
- Where additional space is required, use a separate sheet of paper, which must be signed and dated by the producer, Proposed Insured and Owner, if different from the Proposed Insured.
- For medically underwritten products, you are responsible for ordering requirements (refer to the Age & Amount requirements charts in the Underwriting Guide).
- Make sure all applicable questions are answered and that the answers are legible.
- When faxing, make sure pages are straight to avoid cutting off form numbers during submission.

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

Proposed Insured/Owner	Payer	Producer
✔ Initialed all corrections (do not use white out), if any, and signed the Signature section *(Proposed insured and Owner)* ✔ Signed and dated any supplemental sheets of paper (if required) *(Proposed insured and Owner)* ✔ Initialed the TIA Acknowledgement (if pre-conditions not met) *(Owner only)*	✔ Signed the PAC Authorization (if applicable)	✔ Initialed all corrections, if any, and signed the Producer Certification section ✔ Signed and dated any supplemental sheets of paper (if required)
Send to Foresters	**Leave with Owner**	**Leave with Proposed Insured**
✔ The completed application and the Producer Report page. If applicable: ✔ First premium ✔ Void check ✔ Underwriting questionnaire(s) ✔ State and Foresters replacement/rollover/surrender/disclosure forms ✔ Completed Contingent Owner/Other Payer Identification form ✔ Signed Illustration or illustration certification form ✔ Notice and Consent for Blood and Body Fluid Testing (medically underwritten products)	✔ TIA Agreement (if pre-conditions are met) ✔ Disclosure forms (e.g. Accelerated Death Benefit Rider Disclosure) ✔ Buyer's Guide If applicable: ✔ State and Foresters replacement/rollover/surrender forms ✔ Signed Illustration or illustration certification form	✔ Notices

Foresters Difference

- We believe in enriching lives and building strong communities – that's our purpose. It has defined us since 1874, and it helps us continually redefine what a financial services provider can do for you and your family.
- We believe that you deserve more than a financial services provider – you deserve a partner that will help you prosper and improve your community.
- Foresters is a fraternal benefit society and as such, some aspects of our ownership and beneficiary rules are different than other carriers. Be sure to read the rules found in the Toolbox/Underwriting Resources section of Foresters producer website before taking an application for Foresters products.

Questions? Go to Foresters producer website ezbiz (https://ezbiz.foresters.com)

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Application for Individual Life Insurance

Proposed Insured

First name: ______________ Middle name: ______________ Last name: ______________

Product Details (There may be additional Disclosure forms required. Check the State requirements.)

Your Term Life (Complete only if applying for term life insurance.)

Certificate (Each field in this section must be completed.)

Amount of life insurance applied for on the proposed insured: $ ______________ Underwriting: ○ Non-medical ○ Medical

Depending on the amount of insurance applied for, you can elect to apply under medical or non-medical underwriting criteria. If you apply under medical underwriting criteria, where additional assessment factors, such as medical tests (e.g. blood test) or examinations, may be required, coverage may be issued with lower premium rates, depending on the outcome of our review of these additional factors.

Term: ○ 10 year ○ 15 year ○ 20 year ○ 25 year ○ 30 year

Riders (Subject to state and product availability.)

○ Accidental death: $ ______________	○ Children's term: $ ______________	○ Waiver of premium

SMART Universal Life (Complete only if applying for universal life insurance.)

Certificate (Each field in this section must be completed.)

Amount of life insurance applied for on the proposed insured: $ ______________ Underwriting: ○ Non-medical ○ Medical

Depending on the amount of insurance applied for, you can elect to apply under medical or non-medical underwriting criteria. If you apply under medical underwriting criteria, where additional assessment factors, such as medical tests (e.g. blood test) or examinations, may be required, coverage may be issued with lower cost of insurance rates, depending on the outcome of our review of these additional factors.

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

Life insurance qualification test: ○ Guideline Premium Test (GPT) ○ Cash Value Accumulation Test (CVAT)	Death benefit option: ○ Level ○ Increasing

Under the guideline premium test the sum of the premiums paid, at any time, cannot exceed the greater of (a) the guideline single premium or (b) the sum of the guideline level premiums, at that time. Under the cash value accumulation test the certificate's account value, at any time, cannot exceed the net single premium. Note: You may request a certificate illustration for each test prior to making your election. The elected test cannot be changed after the certificate is issued.

Initial lump sum premium? ○ Yes ○ No

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

1035 exchange funds $ ______________

Non-1035 exchange funds $ ______________ Source of non-1035 exchange funds: ______________

____

Riders (Subject to state and product availability.)

○ Accidental death: $ ______________	○ Children's term: $ ______________	○ Waiver of monthly deductions

Advantage Plus II Whole Life (Complete only if applying for whole life insurance.)

Certificate (Each field in this section must be completed.)

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

Depending on the amount of insurance applied for, you can elect to apply under medical or non-medical underwriting criteria. If you apply under medical underwriting criteria, where additional assessment factors, such as medical tests (e.g. blood test) or examinations, may be required, coverage may be issued with lower premium insurance rates, depending on the outcome of our review of these additional factors.

Plan Type: ○ Paid-up at 100 ○ 20 Pay

Underwriting: ○ Non-medical ○ Medical

Dividend Option: ○ Paid-up additions ○ Paid in cash ○ Left on deposit ○ To reduce premiums

Automatic premium loan provision elected? ○ Yes ○ No

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

If "No", the certificate's Nonforfeiture provisions will automatically apply, if premium is overdue at the end of the Grace Period, resulting in either reduced coverage or surrender.

Riders (Subject to state and product availability.)

○ Accidental death:
$ ____________________

○ Children's term:
$ ____________________

○ Guaranteed insurability

Term: ○ 10 year ○ 20 year
$ ____________________

○ Waiver of premium

○ Flexible payment paid-up additions

Maximum annual payment amount: $ ____________________

Planned payment amount (by mode): $ ____________________
(must be the same mode as premiums for certificate)

The planned payment amount will be added to the total premium for the certificate and rider(s), if any, to determine the amount of each billing, if direct bill, or of each draft, if PAC or another automatic payment option, is elected for payment of premium.

○ Single payment paid-up additions

Planned payment amount: $ ____________________

Payment method:

○ Check ○ PAC (planned payment amount will be added to the amount to be drafted as first premium payment).

○ Transfer ○ Other ____________________

Source of payment: ____________________

Charity Benefit Designation (Complete to designate a charitable organization for the Charity Benefit.)

Charity Benefit Beneficiary Designation

The life insurance product applied for will, if issued, include a Charity Benefit. The owner can designate an eligible beneficiary for that benefit now or at any time prior to the insured's death. If an eligible beneficiary is not designated prior to the insured's death, no Charity Benefit will be paid. Eligible beneficiary means a charitable organization accredited as tax exempt under section 501(c)(3) of the Internal Revenue Code and eligible to receive a charitable contribution as defined in section 170(c) of that code, or any successor provision(s) thereto.

Charitable Organization Name: ____________________ Tax I.D. #: ____________________

Street Address: ____________________ City: ____________________ State: ______ Zip: __________

Remarks

Proposed Insured

First name	Middle name	Last name	○ Male ○ 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? ○ Yes ○ No
If "No", immigration status: ○ Green card holder ○ Permanent resident ○ Other (provide Visa type): ____________________

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

Occupation & duties

○ Full time ○ Part time ○ Seasonal	Income (past 12 months): $	Active duty military or reserves? ○ Yes ○ No

Foresters member? ○ Yes ○ No, applying for membership.	Email	Primary language: ○ English ○ Spanish

Owner (Complete only if other than the proposed insured. If there is to be a contingent owner, use the Contingent Owner/Other Payer I.D. Form.)

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust	Social security # / Tax I.D. #

Street address	City	State	Zip

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

Relationship to the proposed insured	Email

Phone #	If Trust, name of Trustee	If Trust, date of Trust agreement

If Individual:	○ Male ○ Female	Date of birth (mmm/dd/yyyy)

U.S. citizen? ○ Yes ○ No
If "No", immigration status: ○ Green card holder ○ Permanent resident ○ Other (provide Visa type): ____________________

Beneficiary (If "irrevocable" is selected as the beneficiary type, certain transactions cannot be done without the consent of each irrevocable beneficiary. The changes, requiring that consent, include revoking that beneficiary or changing their share and may also include surrendering the insurance contract, taking a loan, changing the ownership or withdrawing values from the insurance contract.)

To designate additional beneficiaries, an overflow form or an additional piece of paper, if signed and dated, can be attached to this application.

Primary

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Contingent

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Name:
Social Security #: Home phone #:
Address:

Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	Beneficiary Type: ○ Revocable ○ Irrevocable	% Share

Financial Questions

Question	Answer
1. Is there an understanding or agreement, whether in writing or not, or has an offer been made to: a) Borrow or be given money, or other property, to pay for or enter into the insurance contract applied for? If "Yes", provide details.	○ Yes ○ No
b) Sell, transfer or assign an insurance contract issued as a result of this Application? If "Yes", provide details.	○ Yes ○ No

For each "Yes" answer to a question in the Lifestyle, either Medical, a Rider or the Other Insurance section, providing details in the Additional Information section or completing the corresponding questionnaire may be required. For purposes of these questions, "you" and "your" mean the proposed insured, "diagnosed", "tested", "advised", "treated", "counseling" and "treatment" mean by a licensed physician or medical practitioner.

If additional space is required, an overflow form or an additional piece of paper, if signed and dated, can be attached to this application.

Lifestyle Questions

Question	Answer
2. Within the past 12 months, have you used tobacco, in any form, or another nicotine product? If "Yes", specify: ○ Cigarettes ○ Other	○ Yes ○ No
3. Within the past 5 years, have you: a) Used marijuana (more than once a week), heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or another controlled substance except as prescribed by a licensed physician or medical practitioner?	○ Yes ○ No
b) Received or been advised to receive treatment or counseling for, or to discontinue or reduce, the use of alcohol, or a non-prescribed or prescribed drug?	○ Yes ○ No
4. Do you expect, within the next 2 years, to change your country of residence or to travel outside of the United States, Canada, Caribbean Islands (excluding Haiti), Western Europe, Hong Kong, Australia or New Zealand?	○ Yes ○ No
5. Within the past 2 years, have you: a) Flown, or do you intend within the next 2 years to fly, in an aircraft as a student pilot or licensed pilot?	○ Yes ○ No
b) Engaged, or do you intend within the next 2 years to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?	○ Yes ○ No
6. Within the past 5 years, have you had your driver's license suspended or revoked or been convicted of more than 3 moving violations or to 1 or more driving while impaired or under the influence violations?	○ Yes ○ No
7. a) Within the past 10 years, have you been convicted of a felony?	○ Yes ○ No
b) Are you currently on parole, incarcerated, or serving probation or within the past 12 months have you served probation?	○ Yes ○ No

PART 1: Medical Questions

8. Your: Height (ft/in): ________________ Weight (lbs): ________________

Question	Answer
9. a) Date you last consulted a physician: Physician Name: Address: Phone #: b) Reason(s) you last consulted a physician:	
c) Were you advised that results of that consultation were outside normal ranges?	○ Yes ○ No
10. Are you currently taking prescription medication or under treatment?	○ Yes ○ No
11. Have you ever been diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection?	○ Yes ○ No
12. Within the past 2 years, have you: a) Had or been advised to have a test (other than for HIV) such as an EKG, CT scan, bone scan, MRI scan, colonoscopy, echocardiogram, angiogram, biopsy, or endoscopy?	○ Yes ○ No
b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known?	○ Yes ○ No

13. Do you currently: a) Reside in a nursing home or skilled nursing facility or psychiatric facility, or are you receiving or been advised to receive, skilled nursing care, hospice care, or home healthcare for a terminal condition that is expected to result in death within the next 12 months or for a chronic condition? b) Require the use of a wheelchair due to a chronic illness or disease? c) Require assistance with activities of daily living such as taking medications, bathing, dressing, eating, or toileting?	 ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
14. Within the past 3 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for sleep apnea, seizures or epilepsy?	○ Yes ○ No
15. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for: a) Diabetes, high blood pressure, a disease or disorder of the blood (other than HIV) or lymphatic system, coronary artery disease, heart murmur, chest pain, irregular heartbeat, aneurysm, stroke, transient ischemic attack, congestive heart failure (CHF), a disease or disorder of the arteries or valves, peripheral vascular or arterial disease (PVD or PAD), or had a heart attack, heart surgery, heart procedure or circulatory surgery? b) Cancer (excluding skin cancer that is basal cell carcinoma), tumor, gastrointestinal bleeding, unexplained weight loss, or a disease or disorder of the pancreas or endocrine system? c) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, or a disease or disorder of the respiratory system or do you currently require the use of oxygen equipment? d) Dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, Lou Gehrig's disease (ALS), muscular dystrophy, fibromyalgia, or a disease or disorder of the brain or nervous system? e) Anxiety, depression, manic depression, bi-polar disorder, schizophrenia or a mental health disorder? f) Blood in the urine, hepatitis, Crohn's disease, Systemic Lupus, cirrhosis, or a disease or disorder of the liver, prostate, bladder, kidney, genito-urinary organs, connective tissue or the digestive or immune system (other than HIV)?	 ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
PART 2: Additional Medical Questions (Complete only if applying for a medically underwritten product.)	
16. Have you ever used tobacco, in any form, or another nicotine product? If "Yes", specify: Type used: ____________ Date last used: ____________ If currently smoking, how many pack(s) per day? ____________	○ Yes ○ No
17. Do you currently drink alcohol? If "Yes", specify: How many times per week? ________ How many drinks per occasion? ________	○ Yes ○ No
18. Within the past 5 years, have you consulted a physician other than identified in question 9, or a medical practitioner, or been treated, tested or monitored in a clinic, hospital or emergency room?	○ Yes ○ No
19. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for high cholesterol?	○ Yes ○ No
20. Net worth: $ ____________	
21. Primary Physician Name (if different from question 9): ____________ Address: ____________ Phone #: ____________	
22. Do you have, alive or deceased, a parent or sibling diagnosed with or treated for, prior to age 65, diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, or another hereditary disorder?	○ Yes ○ No

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

Waiver Rider Questions (Complete only if applying for waiver coverage.)

23. a) Hours worked per week (past 6 months): ________ b) # of weeks worked (past 12 months): ________

24. Within the past 2 years, have you been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?	○ Yes ○ No
25. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for arthritis or for a disease or disorder of the back, neck or musculoskeletal system?	○ Yes ○ No

Children's Term Rider Questions (Complete only if applying for children's term coverage.)

Name of child (First, Middle, Last) under 18 years old (must be a child of the proposed insured)	Gender (M or F)	Date of birth (mmm/dd/yyyy)	Height (ft/in)	Weight (lbs)	Total amount of coverage in force (with all insurers)

26. Has a child listed above: a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disease or disorder? If "Yes", complete the chart below.	○ Yes ○ No

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

b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known? If "Yes", complete the chart below.	○ Yes ○ No

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

Other Insurance (Complete required State and Foresters Replacement/Rollover/Surrender/Disclosure forms. Some states require replacement forms to be completed even if existing insurance is to be kept in force.)

27. Is there another annuity or life insurance application pending, on the life of the proposed insured, with Foresters or another insurer? ○ Yes ○ No

28. Do you currently have an annuity or any of the following types of insurance pending or in force: life, accidental death, critical illness, disability income, long-term care, nursing home or home care insurance? ○ Yes ○ No

If "Yes", to either question 27 or 28, complete the chart below. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those lapsed or surrendered within the past 13 months.

Name of Insurer	Type of Insurance	Amount of Insurance	Issue year or indicate if pending	Replacing ? (Y/N)

29. Have you ever had an application for life, health, disability or critical illness insurance declined, rated or modified? ○ Yes ○ No

If "Yes", provide date and reason:

30. Is there an intention that coverage will be discontinued or reduced, or premium payments stopped, on existing life insurance coverage or an annuity, if the insurance applied for in this Application is issued (includes military group life insurance)? ○ Yes ○ No

31. Is there an intention that coverage will be discontinued or reduced, or premium payments stopped, on existing long-term care insurance, nursing home insurance, home care insurance or life insurance that allows for the acceleration of the death benefit due to chronic illness, if the insurance applied for in this Application is issued? ○ Yes ○ No

Additional Information (Explain all "Yes" answers where applicable.)

Include Question #, diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone #s.

Payment Information and Authorization (The planned premium quoted may change following underwriting review.)

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

Payment mode: ○ Monthly (not available for direct bill) ○ Quarterly ○ Semi-annually ○ Annually

First premium payment to be made by: ○ Pre-Authorized Check (PAC) ○ Check (payable to Foresters) ○ Other ____________________

Subsequent premium payments to be made by: ○ Pre-Authorized Check (PAC) ○ Direct Bill ○ Other ____________________

Preferred draft date: ○ No ○ Yes, draft on the ______ day (between 1st and 28th) of the month.

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

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

Type of account: ○ Checking ○ Savings

Name of financial institution: ____

Routing Transit #: ______________________________ Account # : ______________________________

PAC Authorization

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

This authorization must be signed by the bank account owner as his/her name appears on bank records for the account provided.

X ____
(Signature of payer)

Conversion Notification

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

Temporary Life Insurance Agreement (TIA) Questions & Acknowledgement

Has the proposed insured:

1. Within the past 24 months, had either an investigation or treatment, by a licensed physician or medical practitioner, for chest pain, heart problem, stroke or cancer, or been diagnosed with or treated for AIDS or HIV infection by a licensed physician or medical practitioner?	○ Yes ○ No
2. Within the past 4 months, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)?	○ Yes ○ No
3. Within the past 4 months, had surgery performed or recommended, had or been medically advised to have a medical test (other than for HIV) or investigation, that has not yet been started or completed, or the results of which are not yet known?	○ Yes ○ No

TIA Acknowledgement: Were all of the pre-conditions to temporary coverage met?

○ No (Do not provide a check for first premium payment). The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is authorized. **X** ________ (Owner's initials)

○ Yes. I, the owner, understand that temporary coverage is subject to, and I had the opportunity to review, the Temporary Life Insurance Agreement. First premium payment, in the amount of $ ____________, is authorized, provided or collected by (select same method chosen in the Payment Information and Authorization section):

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

Although the first premium payment amount shown above is subject to change following underwriting, this amount must be at least equal to the monthly premium quoted for the insurance, including each rider, applied for in this Application.

Secondary Addressee (Complete only if designating another person to receive notification regarding a possible lapse in coverage.)

First name	Middle name	Last name		○ Male ○ Female
Street address		City	State	Zip

Declarations and Agreements

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

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true, to the best of my knowledge and belief. 4) If I am the owner and if the amount of life insurance applied for on the life of the proposed insured is at least $20,000, I have been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

I understand and agree that: 1) All statements made in this Application by me shall be representations and not warranties. 2) This Application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently amended shall form part of the entire contract if an insurance contract is issued by Foresters. 3) No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) A material misrepresentation may result in loss of coverage or cancellation of the insurance contract. 6) A Foresters insurance contract issued, if any, as a result of this Application comes into effect according to its terms, and then only if the first premium due, for that insurance contract, is provided in full on or before the delivery date of that insurance contract and is received by Foresters from the financial institution from which it is to be collected. 7) Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identity.

I further understand and agree that: 1) Changes or corrections made to this Application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. Such changes or corrections may be made directly on this Application or by an amendment to this Application. 2) No producer, medical examiner or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to make, modify, or discharge an insurance contract. 3) This Application and related documents may be completed, signed and/or submitted to Foresters by voice and/or electronic means and if completed in paper form this original Application may be destroyed after confirmation of successful transmission. 4) At my revocable option, Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 5) I understand that providing an email address is optional. If I have chosen to provide an email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 6) **The certificate(s) that Foresters issues, if at all, as a result of this Application, may have attached, for no additional premium or cost of insurance, a rider providing for an accelerated death benefit. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. The accelerated death benefit may be subject to an actuarial discount and an administrative fee; the administrative fee will be no more than $500.00.**

Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) obtaining reinsurance, (c) administering the insurance contract, and (d) administrating claims and, to the extent obligated, paying benefits. In this authorization, "proposed insured", "owner" and "parent/legal guardian" mean each person identified as such in this Application. "Child" means each child named, if any, and proposed for insurance, in this Application. "Authorized persons" means reinsurers, insurance agents, agencies, and Foresters subsidiaries and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business analysis and operations. As evidenced by the signature(s) in the Signature Section of this Application, the proposed insured and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or MIB, Inc. ("MIB"). This includes obtaining records or other information available as to: past, current or future diagnosis, treatment and prognosis of a physical or mental condition; past, current or future physical and mental health information (excluding psychotherapy notes) that may be protected by federal or state laws and regulations. Information may be disclosed: between and among Foresters and authorized persons; to companies to which the proposed insured has or may apply to for insurance coverage or benefits; as required or permitted by law. The proposed insured, and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons, to make a brief report of the proposed insured's and each child's personal and/or protected health information to MIB, even if this Application is cancelled or withdrawn. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this Application. A copy of this authorization shall be as valid as the original. Each person signing this authorization may at any time, by written notice to Foresters, revoke their authorization. Revocation is not effective to the extent that Foresters, or an authorized person, has acted in reliance on the authorization prior to notice of revocation. A Notices page has been provided, either in paper or electronically, to the proposed insured. It includes the MIB and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

Signature Section (For purposes of entire Application and, if applicable, the Temporary Life Insurance Agreement.)

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

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

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

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

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

Producer Certification

Unless specifically stated otherwise in the Producer Report, I certify each of the following:

a) I am not aware of undisclosed information about the health, habits or lifestyle of the proposed insured or a child, identified in this Application, that might affect insurability. b) I asked the proposed insured, the parent/legal guardian if the proposed insured is a juvenile, and/or the owner each question as written in this Application to which an answer is shown, and recorded the answers as given to me by each person. c) This Application was reviewed by each person signing in the Signature Section before it was signed by that person. d) This Application has not been altered in any way after the proposed insured, the parent/legal guardian if the proposed insured is a juvenile, and owner signed it. e) I complied with applicable regulatory requirements including those relating to the solicitation and sale of life insurance to active duty members of the United States military. f) If applicable, I have disclosed that this Application, if completed in paper form, may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission. g) I have made no misrepresentation(s) about Foresters product(s) applied for in this Application. I have made no promise(s) regarding the benefit(s) or future performance of the product(s) applied for, other than as specifically written in the specific product(s) applied for in this Application. h) If the amount of life insurance applied for on the life of the proposed insured is at least $20,000, the owner has been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

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

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

Did you personally meet with the proposed insured and owner and review the document(s) used to verify identity and birth date of each person? ○ Yes ○ No

Producer's name (print full name): ______________________ Producer #: ____________

Producer's signature: **X** ______________________ Date: ____________
(mmm/dd/yyyy)

The Independent Order of Foresters ("Foresters")

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

Temporary Life Insurance Agreement (TIA) (Complete and leave with the owner only if all pre-conditions are met.)

Definitions - "Application" means the Application for Individual Life Insurance to which this Agreement relates. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters. "Producer" means the person who signed the Application as the producer. "Proposed Insured" and "Owner" mean the person(s) identified as such in the Application.

Pre-Conditions to Temporary Coverage - Subject to the terms of this Agreement, we agree to provide the temporary coverage set out in this Agreement, effective on the date the Application is signed by the owner, if each of the following pre-conditions are met: 1) The proposed insured is not, on that date, less than 15 days old or age 71 or older. 2) No more than $1,000,000 of life insurance on the proposed insured is applied for in the Application, not including coverage or benefits, if any, to be provided by rider(s), whether applied for or not. 3) Each question in the Temporary Life Insurance Agreement (TIA) Questions section is answered "No" and each "No" answer shown is truthful, to the best of the proposed insured and owner's knowledge and belief and 4) No later than the date the Application is signed by the owner, first payment, at least equal to a monthly premium quoted for the insurance, including each rider, applied for in the Application, is provided or authorized by a method other than a transfer of funds from existing life insurance or annuity contract(s). If one or more of the above pre-conditions are not met, no temporary coverage takes effect even if this Agreement was left with the owner.

Temporary Life Insurance Agreement (TIA) Questions

Has the proposed insured:	
1. Within the past 24 months, had either an investigation or treatment, by a physician or medical practitioner, for chest pain, heart problem, stroke, cancer or AIDS ("Investigation" does not include tests for HIV)?	○ Yes ○ No
2. Within the past 4 months, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)?	○ Yes ○ No
3. Within the past 4 months, had surgery performed or recommended, had or been medically advised to have a medical test (other than for HIV) or investigation, that has not yet been started or completed, or the results of which are not yet known?	○ Yes ○ No

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

Termination of Temporary Coverage - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate comes into effect as described in that certificate, if a certificate is issued in response to the Application. 3) The issue date, as shown in our records, for an approved Foresters certificate issued in response to the Application if that certificate either does not meet the conditions to come into effect, as described in that certificate, or is rescinded. 4) The date we offer, as shown in our records, the owner a Foresters certificate in response to, but not as applied for in, the Application. 5) The date a written request to cancel or withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 6) The earlier of (a) the fifth day after the date written notice is sent by us, as shown in our records, to the proposed insured or the owner, terminating this Agreement, cancelling or declining the Application, or (b) the date that such written notice is received by the proposed insured or the owner.

Special Limitations - This Agreement shall be void if the first payment, regardless of method, is not honored when presented for payment. Material misrepresentation in the Application will void this Agreement and limit our liability to a refund of payment(s) made to us. If the proposed insured dies by suicide, whether sane or insane, our liability under this Agreement is limited to a refund of the payment(s) made to us.

Entire Agreement and Governing Law - This Agreement contains the entire terms regarding temporary coverage. No one, including the producer, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement. This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

Acknowledgement - I, the proposed insured and owner, if other than the proposed insured, by signing in the Signature Section of the Application, acknowledge and agree that I have reviewed, understand and accept the terms of this Temporary Life Insurance Agreement.

Countersigned,

James R. Boyle, President & Chief Executive Officer

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Accelerated Death Benefit Rider Disclosure (This disclosure must be given to the owner.)

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

Benefit Description

The rider, while in effect, 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"). The rider will not be in effect if the certificate that it is attached to expires, lapses, terminates or is cancelled, converted or surrendered. Additionally, if attached to a term certificate, the rider will not be in effect after the end of the initial term period. Under the conditions described in the rider the owner may elect to receive a payment if the insured is diagnosed with a chronic illness, by the applicable licensed health care practitioner, or with a critical or terminal illness, by the applicable physician. 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. No payment will be made for an illness that results directly or indirectly from attempted suicide or intentionally self-inflicted injury, that occurs within two years from the date the rider comes into effect.

Notice to Prospective Owner: The rider may not cover all of the costs associated with the chronic illness of the insured. The rider may also not cover all of the costs associated with the critical and terminal illness of the insured. You are advised to carefully review the rider benefits. There is no relationship between the cost of care for the insured and the benefits provided under the rider.

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

Chronic illness means the insured, within the preceding 12 month period, has been certified by a licensed health care practitioner as:

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

The chronic illness must be diagnosed as requiring continuous care for the remainder of the insured's life, in an eligible facility or at home, according to a plan of care for the insured at the time of certification.

Critical illness means the insured has been certified by a physician as having one or more of the following, as defined in the rider: End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack) or Stroke.

Terminal illness means the insured has been certified by a physician as having an illness or physical condition which is reasonably expected to result in death within 12 months of diagnosis.

Amount of the Accelerated Death Benefit Payment

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

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

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

Each acceleration amount must be at least $4,500.00 and must be such that after acceleration a residual face amount of at least $10,000.00 remains. The total of all acceleration amounts cannot exceed the lesser of 95% of the eligible death benefit on the effective date of the first payment and $500,000.00. For chronic illness the maximum amount that can be accelerated for a benefit period is the lesser of 24% of the eligible death benefit on the effective date of the first payment due to a chronic illness and the amount that would result in the total amount(s) received for the applicable 12 month per diem limitation period, for which the insured has been certified as having a chronic illness, equaling the per diem limitation under section 7702B(d) of the Internal Revenue Code. For this purpose total amount(s) will include: (a) the unpaid total premium and the loan repayment amount deducted in calculating the payment; and (b) amounts received or expected from other coverage (through insurance or otherwise) that will reduce or count against the per diem limitation for the applicable 12 month per diem limitation period. For critical and terminal illness, the maximum amount that can be accelerated is 95% of the eligible death benefit on the effective date of the payment.

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Effect of Payment on the Certificate

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

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.

The rider is not, and is not intended to be, federally tax-qualified long-term care insurance under 7702B(b) of the Internal Revenue Code.

Examples of Accelerated Death Benefit Payments

The following examples are hypothetical and are 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. These examples are based upon a 30 year term life insurance certificate, issued when the insured was age 45. The chronic illness example is based upon the maximum acceleration amount being accelerated and the critical and terminal illness examples are based upon 50% of the maximum acceleration amount being accelerated. The amounts, including the accelerated death benefit payments, shown are based upon hypothetical certificate values at the time of acceleration, are not guaranteed, and assume that the claim has been approved when the certificate has been in effect for the number of years indicated. Actual amounts will vary and may be higher or lower depending on a number of factors, including but not limited to, the type of certificate, the actual certificate values at the time the claim is approved, the age of the insured and the length of time that the certificate has been in effect.

Effect on Certificate Values

	Before Acceleration	After Acceleration		
		Chronic Illness	Critical Illness	Terminal Illness
Face Amount:	$ 200,000.00	$ 152,000.00	$ 105,000.00	$ 105,000.00
Annual Premium:	$ 984.00	$ 764.64	$ 549.85	$ 549.85

Accelerated Death Benefit Payment Calculation (Claim approved when certificate has been in effect for 10 years.)

	Chronic Illness	Critical Illness	Terminal Illness
Acceleration Amount:	**$ 48,000.00**	**$ 95,000.00**	**$ 95,000.00**
Payment Percentage:	15.022 %	30.742 %	100.00 %
Gross Payment Amount:	$ 7,210.56	$ 29,204.90	$ 95,000.00
minus **Administrative Fee:**	$ 300.00	$ 300.00	$ 0.00
minus **Overdue Premium:**	$ 0.00	$ 0.00	$ 0.00
Accelerated Death Benefit Payment:	**$ 6,910.56**	**$ 28,904.90**	**$ 95,000.00**

For chronic and critical Illness the actuarial discount will generally be higher for claims approved in the early years of a certificate and lower in the later years. This could result in significantly lower accelerated death benefit payments in earlier years than in later years on the same certificate. To illustrate this, the following chart shows hypothetical payment amounts for a critical illness claim, on the same hypothetical term life insurance certificate issued when the insured was age 45, approved in different years.

Year	Acceleration Amount	Accelerated Death Benefit Payment	Year	Acceleration Amount	Accelerated Death Benefit Payment
2	$95,000.00	$ 20,154.60	15	$95,000.00	$ 32,672.59
5	$95,000.00	$ 21,696.12	20	$95,000.00	$ 36,045.90
7	$95,000.00	$ 24,411.57	25	$95,000.00	$ 38,640.59

The same effect occurs, although the values and amounts will be different, if the certificate is universal life or whole life insurance.

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

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

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

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, we may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character and general reputation. They may also include personal characteristics, such as health, prescription history, finances, job and mode of living. The federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from Foresters about the nature and scope of an investigation. We will provide the contact information of any agency we ask to prepare such a report. You may contact the agency to learn about the contents or request a copy of the report. You may request a personal interview with the agency and they will make a reasonable attempt to talk to you. It will include that information in its report. If we order a report, it may include information obtained through interviews with your neighbors, friends or others you know.

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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APPENDIX 11
INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE PRODUCER OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? . . . . ○ YES ○ NO
2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? . . . . ○ YES ○ NO
3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? . . . . ○ YES ○ NO
4. REISSUED WITH REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? . . . . ○ YES ○ NO
5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? . . . . ○ YES ○ NO
6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? . . . . ○ YES ○ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR PRODUCER OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

Date: ______ Signature of Applicant: ______

Date: ______ Signature of Applicant: ______

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: . . . . . ○ YES ○ NO

Date: ______ Signature of Producer or Broker: ______

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INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE PRODUCER OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? . . . . ◯ YES ◯ NO
2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? . . . . ◯ YES ◯ NO
3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? . . . . ◯ YES ◯ NO
4. REISSUED WITH REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? . . . . ◯ YES ◯ NO
5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? . . . . ◯ YES ◯ NO
6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? . . . . ◯ YES ◯ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR PRODUCER OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

Date: ____________ Signature of Applicant: ____________

Date: ____________ Signature of Applicant: ____________

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: . . . . . ◯ YES ◯ NO

Date: ____________ Signature of Producer or Broker: ____________

Producer Report

Proposed Insured

First name: ______________________ Middle name: ____________ Last name: ______________________

Producer's name	Producer #	% of split

1. Indicate the anticipated rating class: ______________________

   If underwriting approval is for a rating class other than as anticipated, Foresters will contact you and, if we do not receive direction otherwise, the certificate will be issued to maintain face amount.

Question	Answer
2. Should the certificate's issue date be adjusted to save the insurance age? If "Yes", additional premium may be required.	○ Yes ○ No
3. Is the proposed insured you, your spouse/partner or your child/stepchild?	○ Yes ○ No
4. In the Application, are you the owner, payer or beneficiary?	○ Yes ○ No
5. Have you submitted an additional application to Foresters on a family member of the proposed insured or owner (if other than the proposed insured)? If "Yes", list the name(s) in the Producer Comments section below.	○ Yes ○ No
6. Was a copy of the Buyer's Guide provided to the owner at the time of sale?	○ Yes ○ No

7. Indicate in the chart below if age & amount requirements were ordered (only if applying for a medically underwritten product).

Age & Amount Requirements	Vendor	Date ordered
Vitals, paramed or medical (with or without lab tests)		

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

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

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

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

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

Illustration Certification

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

Proposed Insured's Name: ____________________________________ **Plan Applied For**: ___________________________________

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

Producer's Certification

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

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

Prospective Owner's Certification

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

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

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

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Illustration Certification

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

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

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

Producer's Certification

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

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

Prospective Owner's Certification

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

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

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

New York Compensation Disclosure

The following disclosure is provided pursuant to Insurance Department Regulation No. 194 (11 NYCRR 30.1 et seq.):

_________________________________ is an insurance producer licensed by the State of New York. Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction typically involves one or more of these activities.

Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) and insurance contract(s) the purchaser selects, compensation will be paid by the insurer(s) selling the insurance contract or by another third party. Such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchaser selects. In some cases, other factors such as the volume of business a producer provides to an insurer or the profitability of insurance contracts a producer provides to an insurer also may affect compensation.

The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and (if applicable) compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by requesting such information from the producer.

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Foresters Financial

APPENDIX 10C

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY REGULATION NO. 60

YOU ARE CONTEMPLATING THE PURCHASE OF A LIFE INSURANCE POLICY OR ANNUITY CONTRACT IN CONNECTION WITH THE SURRENDER, LAPSE OR CHANGE OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. THE PRODUCER OR BROKER IS REQUIRED TO GIVE YOU THIS NOTICE TOGETHER WITH A SIGNED DISCLOSURE STATEMENT CONTAINING THE SUMMARY RESULT COMPARISON FOR THE NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT AND ANY LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO BE CHANGED THAT SETS FORTH THE FACTS OF THE TRANSACTION AND ITS ADVANTAGES AND DISADVANTAGES TO YOU. YOUR DECISION COULD BE A GOOD ONE - OR A MISTAKE - SO MAKE SURE YOU UNDERSTAND THE FACTS. YOU SHOULD:

1. CAREFULLY STUDY THE DISCLOSURE STATEMENT, WHICH INCLUDES A SUMMARY RESULT COMPARISON, UNTIL YOU ARE SURE YOU UNDERSTAND FULLY THE EFFECT OF THE TRANSACTION.
2. ASK THE COMPANY, PRODUCER OR BROKER FROM WHOM YOU BOUGHT YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO REVIEW WITH YOU THE TRANSACTION AND THE DISCLOSURE STATEMENT. YOU MAY BE ABLE TO EFFECT THE CHANGES YOU DESIRE MORE ADVANTAGEOUSLY WITH THEM. THEIR CUSTOMER SERVICE TELEPHONE NUMBER IS CONTAINED IN THE DISCLOSURE STATEMENT.
3. CONSULT YOUR TAX ADVISOR. THERE MAY BE UNFAVORABLE TAX IMPLICATIONS ASSOCIATED WITH THE CONTEMPLATED CHANGES TO YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured’s then attained age.
2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore a replacement involving annuity contracts may result in the imposition of surrender charges.
3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.
4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.

5. There may have been changes in your health since the purchase of the existing coverage.
6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

YOU HAVE THE RIGHT, WITHIN 60 DAYS FROM THE DATE OF DELIVERY OF A NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT, TO RETURN IT TO THE INSURER AND RECEIVE AN UNCONDITIONAL FULL REFUND OF ALL PREMIUMS OR CONSIDERATIONS PAID ON IT, OR IN THE CASE OF A VARIABLE OR MARKET VALUE ADJUSTMENT POLICY OR CONTRACT, A PAYMENT OF THE CASH SURRENDER BENEFITS PROVIDED UNDER THE POLICY OR CONTRACT, PLUS THE AMOUNT OF ALL FEES AND OTHER CHARGES DEDUCTED FROM GROSS CONSIDERATIONS OR IMPOSED UNDER THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, AND MAY HAVE THE RIGHT TO REINSTATE OR RESTORE ANY LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS THAT WERE SURRENDERED, LAPSED OR CHANGED IN THE TRANSACTION TO THEIR FORMER STATUS TO THE EXTENT POSSIBLE AND IN ACCORDANCE WITH THE INSURER'S PUBLISHED REINSTATEMENT RULES TO THE EXTENT SUCH RULES ARE NOT INCONSISTENT WITH THE PROVISIONS OF THIS PART.

IMPORTANT: THIS RIGHT SHOULD **NOT** BE VIEWED AS REINSTATING OR RESTORING YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT TO THE SAME CONDITION AS IF IT HAD NEVER BEEN REPLACED. THERE MAY BE CONSEQUENCES IN REINSTATING OR RESTORING YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT, INCLUDING BUT NOT LIMITED TO:

- THE RIGHT TO REINSTATE OR RESTORE YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT APPLIES ONLY TO COMPANIES SUBJECT TO NEW YORK INSURANCE LAWS;
- YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT IS SUBJECT TO YOUR SPECIFIC COMPANY'S REINSTATEMENT RULES, WHICH MAY VARY FROM COMPANY TO COMPANY. THESE RULES MAY REQUIRE PAYMENT OF BOTH PREMIUM AND INTEREST; HOWEVER, YOU WILL NOT BE SUBJECT TO EVIDENCE OF INSURABILITY, OR A NEW CONTESTABLE OR SUICIDE PERIOD;
- YOU MAY NOT RECEIVE THE INTEREST OR INVESTMENT PERFORMANCE DURING THE PERIOD THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT WAS REPLACED; AND
- THERE MAY BE UNFAVORABLE FEDERAL INCOME TAX CONSEQUENCES AS A RESULT OF THE REINSTATEMENT OF YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT.

IMPORTANT: IN THE CASE OF A VARIABLE OR MARKET VALUE ADJUSTMENT POLICY OR CONTRACT, THE VALUE OF THE POLICY OR CONTRACT MAY INCREASE OR DECREASE DURING THE 60 DAY PERIOD DEPENDING ON THE PERFORMANCE OF THE UNDERLYING INVESTMENTS, WHICH MAY EFFECT THE VALUE OF THE REFUND YOU RECEIVE.

I HEREBY ACKNOWLEDGE THAT I READ THE ABOVE "IMPORTANT NOTICE" AND HAVE RECEIVED A COPY OF SAME.

Date: ____________ Signature of Applicant: ____________

Date: ____________ Signature of Applicant: ____________

The Independent Order of Foresters ("Foresters")
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APPENDIX 10A
INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DISCLOSURE STATEMENT

IMPORTANT - IT MAY **NOT** BE IN YOUR BEST INTEREST TO SURRENDER, LAPSE, CHANGE OR BORROW FROM EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THE PURCHASE OF A NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT WHETHER ISSUED BY THE SAME OR A DIFFERENT INSURANCE COMPANY. YOU ARE URGED TO CONTACT YOUR EXISTING PRODUCER, BROKER OR INSURANCE COMPANY **PRIOR** TO COMPLETING THE TRANSACTION. THEY CAN HELP YOU DECIDE WHETHER THE REPLACEMENT IS IN YOUR BEST INTEREST.

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure Statement, the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts and the Definition of Replacement, together with policy information on all proposed and existing coverage affected.

Name of Applicant ______________________________ Telephone # ______________________

Address ____

Name of Producer or Broker ______________________ Telephone # ______________________

Company ______________________________ Address ______________________

The information on existing coverage on this form was obtained from

○ The replaced company

○ Approximations if replaced company failed to provide information in the prescribed time

DISCLOSURE STATEMENT CONTINUED:

1. DESCRIPTION OF TRANSACTION: AS OF DATE:

Proposed Policy/Contract		Existing Policies/Contracts Affected (1)	(2)	(3)
________	Company	________	________	________
____– ______	Customer Service Telephone Number:	____– ______	____– ______	____– ______
$ ________	Type of Insurance	$ ________	$ ________	$________
$ ________	Face Amount	$ ________	$ ________	$________
$ ________	Rider ______	$ ________	$ ________	$________
$ ________	Rider ______	$ ________	$ ________	$________
$ ________	Rider ______	$ ________	$ ________	$________
$ ________	Rider ______	$ ________	$ ________	$________
$ ________	Rider ______	$ ________	$ ________	$________
$ ________	Premium	$ ________	$ ________	$________
	Contract Number	# ________	# ________	# ________
	Issue Date	________	________	________

Proposed Policy/Contract		Existing Policies/Contracts Affected (1)	(2)	(3)
$ ______	Surrender Charge	$ ________	$ ________	$ ________
______%	Guaranteed Interest Rate	______%	______%	______%
______%	Loan interest Rate	______%	______%	______%
_____Years	Contestable Expiry Date	______M/Y	______M/Y	______M/Y______
_____Years	Suicide Expiry Date	______M/Y	______M/Y	______M/Y______

DISCLOSURE STATEMENT CONTINUED:

EXISTING COVERAGE TO BE CHANGED BY:

	Lapse or Surrender	[ ]	[ ]	[ ]
	Amendment of Reissue	[ ]	[ ]	[ ]
	Loan or Withdrawal	[ ]	[ ]	[ ]
	Reduction To	$ ______________	$ ______________	$ ______________
	Reduced Paid-up For	$ ______________	$ ______________	$ ______________
	Extended Term For	____Yrs____Mos	____Yrs____Mos	____Yrs____Mos
Cash released by change	Year ______________	$ ______________	$ ______________	$ ______________
	Year ______________	$ ______________	$ ______________	$ ______________
	Year ______________	$ ______________	$ ______________	$ ______________

Use of cash released: ____

2. SUMMARY RESULT COMPARISON:

New With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed	Annual Premium	Guaranteed	Non-Guaranteed
$________________	$________________	At Present	$________________	$________________
$________________	$________________	5 Years Hence	$________________	$________________
$________________	$________________	10 Years Hence	$________________	$________________
Guaranteed	Non-Guaranteed	Surrender Value	Guaranteed	Non-Guaranteed
$________________	$________________	At Present	$________________	$________________
$________________	$________________	5 Years Hence	$________________	$________________
$________________	$________________	10 Years Hence	$________________	$________________
Guaranteed	Non-Guaranteed	Death Benefit	Guaranteed	Non-Guaranteed
$________________	$________________	At Present	$________________	$________________
$________________	$________________	5 Years Hence	$________________	$________________
$________________	$________________	10 Years Hence	$________________	$________________
Guaranteed	Non-Guaranteed	Dividends	Guaranteed	Non-Guaranteed
$________________	$________________	At Present	$________________	$________________
$________________	$________________	5 Years Hence	$________________	$________________
$________________	$________________	10 Years Hence	$________________	$________________

DISCLOSURE STATEMENT CONTINUED:

PRODUCER OR BROKER'S STATEMENT:

1. The primary reason(s) for recommending the new life insurance policy or annuity contract is (are):

2. The existing life insurance policy or annuity contract cannot meet the applicant's objectives because:

3. The advantages of continuing the existing life insurance policy or annuity contract without changes are:

REMARKS:

○ The attached proposal, including sales material, was used in this sale.

○ No proposal or sales material was used in this sale.

If more than three existing life insurance policies or annuity contracts are to be affected by this transaction or if more than one new life insurance policy or annuity contract is proposed, the first page of this Disclosure Statement must be completed for such additional life insurance policies and annuity contracts. In addition, a composite comparison shall be completed for all existing life insurance policies or annuity contracts to all proposed life insurance policies or annuity contracts. The proposal, including sales material used in the sale of the proposed life insurance policy or annuity contract, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: Signature of Producer or Broker:

I hereby acknowledge that I received and read the above "Disclosure Statement" before I signed the application for the new coverage.

Date: Signature of Applicant:

Date: Signature of Applicant:

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Foresters Financial

APPENDIX 11
INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE PRODUCER OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? . . . . ◯ YES ◯ NO
2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? . . . . ◯ YES ◯ NO
3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? . . . . ◯ YES ◯ NO
4. REISSUED WITH REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? . . . . ◯ YES ◯ NO
5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? . . . . ◯ YES ◯ NO
6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? . . . . ◯ YES ◯ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR PRODUCER OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

Date: ____________ Signature of Applicant: ____________

Date: ____________ Signature of Applicant: ____________

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: . . . . . ◯ YES ◯ NO

Date: ____________ Signature of Producer or Broker: ____________

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Authorization and Direction to release life insurance policy
or annuity contract information to the Independent Agent of the Independent Order of Foresters

To: ____

For: Policy(ies) or Contract(s) Number(s) ______________________________
____
____

I/We hereby authorize and direct you to provide to:

Agent Name ___________________________ Phone # _______________ FAX # ________________

Agent Mailing Address ____
City ______________________State ________________ ZIP _________

All information with respect to the policies or contracts identified above which is necessary in order to complete a Disclosure Statement as required by New York State Insurance Department Regulation No. 60,11 NYCRR 51, as amended, from time to time.

This authorization and direction shall be your good and sufficient authority for so doing.
A photocopy of this authorization shall be as valid as the original.

Dated this _________________ day of ________________________________, in the year _______.

______________________________ ______________________________
Witness Owner's signature

______________________________ ______________________________
Owner's name (please print)

______________________________ ______________________________
Witness Co-Owner's signature, if any

____
Co-Owner's name (please print)

Agent will submit Disclosure information to Foresters with application and paperwork.

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Foresters Financial

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE AND THE PURCHASE OF MULTIPLE ACCIDENT AND HEALTH POLICIES

According to your application you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by The Independent Order of Foresters. Your new policy provides 60 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy).

2. You should be aware that the premium rate for the replacement policy may be higher than what you are paying for the existing policy that you plan to replace. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information requested on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on *(Date)*:______________________________

Applicant's Name *(Printed)*: ____

Applicant's Signature: **X** ____

I have reviewed the current health insurance coverage of the applicant and find that replacement and/or additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Producer's Signature: **X** ____

Foresters Financial and Foresters are trade names and trademarks of The Independent Order of Foresters (a fraternal benefit society) and its subsidiaries.

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

NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING

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

The tests to be performed will include a determination of the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test performed is actually a series of tests designed to determine the presence of these antibodies or antigens. If you have been infected with the HIV virus which causes AIDS, your body may have produced HIV antibodies which try to get rid of the infection. Instead of providing a blood sample for initial testing purposes, you may be requested to first provide only a sample of your body fluids (e.g. urine or saliva) for testing. This sample of other body fluids will be tested for evidence of HIV antibodies, kidney disorders, diabetes, and foreign substances such as nicotine and cocaine. If this HIV test is abnormal (positive) or other abnormalities are ascertained, you then will be requested to provide a blood sample for full blood series testing including a confirmatory HIV blood test. Other blood tests which may be performed include determinations of blood cholesterol and related lipids (fats), and screening for diabetes, liver and kidney disorders.

Testing considerations:

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

Meaning of a positive test result:

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

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

Disclosure of test results:

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

Notification fo test results:

If your HIV test results are normal, no notification will be sent to you. If your HIV tests are abnormal, we will contact you, your legal guardian, or the person authorized by you below. Other abnormal test results which, in our opinion, are potentially significant to your health or insurability will be similarly communicated.

If you wish to preauthorize another person for notification of abnormal test results, please provide the name and address below. We encourage you to authorize a physician or other health care provider for the purpose of discussing test results: Additional information concerning AIDS or HIV infection can be obtained by calling the New York Health Department at 1-800-541-2437.

Name of physician or health care provider	Address	City	State	Zip code

Informed consent:

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

Name of insured	Birthdate (dd/mm/yyyy)	State of residence

Signature of proposed insured (parent/guardian)	Date signed by proposed insured (parent/guardian) (dd/mm/yyyy)

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

HIV ANTIBODY TEST INFORMATION FORM FOR INSURANCE APPLICANT

AIDS

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

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

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

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

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. (a) **"ELISA"** test means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus.
   (b) **"Positive ELISA test"** means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.
   (c) **"Western Blot Assay"** means an assay which uses reagents consisting of HIV antigens separated by polyacrylamidegel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus.
   (d) **"Reactive Western Blot Assay"** means an Assay which is reactive according to the standards of performance and results specified in the manufacturer's federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.
   (e) **"HIV antibody test"** means an ELISA test or a Western Blot Assay, or both.
2. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
3. **Positive test results.** If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.
4. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:
   (a) **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   (b) **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.
5. **Side effects.** A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
6. **Disclosure of results.** A positive test result will be disclosed to you or the physician or other designee that you designate.
7. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.
8. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

NY Health Department is 1-800-542-2437 and the NY AIDS Hotline number is 1-800-541-2437

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1035 Exchange/Absolute Assignment Form ("Form")

For Use with New Life Insurance Contracts Only

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

Insured's Name: ______________________________

Owner's Name: ______________________________ **Owner's Social Security Number:** ____________

Existing Company: Name: ______________________________

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

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

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

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

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

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

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Owner's Signature: X____ **Date** *(mmm/dd/yyyy)*: _________________________

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

Name (print full name): ____

Signature: X____ **Date** *(mmm/dd/yyyy)*: _________________________

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

Name (print full name): ____

Signature: X____ **Date** *(mmm/dd/yyyy)*: _________________________

Name (print full name): ____

Signature: X____ **Date** *(mmm/dd/yyyy)*: _________________________

Name (print full name): ____

Signature: X____ **Date** *(mmm/dd/yyyy)*: _________________________

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

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

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

Title: ____ **New Contract Certificate Number:** ______________________

Life Insurance Suitability and Best Interest Form ("Form")
Foresters Your Term, SMART Universal Life, Advantage Plus II Whole Life

This Form must be completed, signed and submitted with an insurance application for a Foresters certificate to be issued or delivered in New York and for a reinstatement by redate. Form not required for additional premium payments. If additional space required, use and submit a separate sheet of paper, signed and dated by the producer and owner.

Name of Owner: ____ Owner Age: _________
(first, middle, last)

Transaction Type:

□ New application to buy the product identified below
□ Reinstatement by Redate of the product identified below (not available for SMART Universal life)

Product (choose one): □ SMART Universal Life □ Advantage Plus II Whole Life □ Your Term

Part A - Owner Suitability Information Section (In Part A, 'you' and 'your' mean the Owner and 'Product' means the product selected in the Transaction Type section of this Form)

Household Financial Information

Household Annual Income: Gross $ _______ Net $ _______ (Net is after tax but before expenses)

Household Assets: $ _____________ Household Liquid Net Worth: $ __________

Household Monthly Financial Obligations $____________ *(indicate total including items such as mortgage, credit cards, loans and other on-going payments (eg. utility bills)).*

Considering the premium you plan to pay for the Product, do you (or your household, if applicable) have sufficient cash or other liquid assets to pay for other expenses and unexpected emergencies?
□ Yes □ No

Do you anticipate material changes in the above income, assets, net worth or financial obligations that would negatively affect your ability to pay for the Product?
Yes No

Will you be taking a loan, refinancing, or going into debt to pay the premiums for the Product?
Yes No

What will be the source of funds for paying premiums for the Product? ________________________

Insurance Need

Do you require a level premium amount for life insurance (premiums won't increase)? Yes No

For how long do you want this life insurance coverage: For life or A period of _____ years

How much do you feel you can afford to pay monthly for this Product, including additional payments you plan to make?
Up to $_________

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What is the purpose for your purchase of the Product? (choose all that apply):

1/ Death benefit proceeds: ☐ final expenses ☐ pay towards mortgage ☐ leaving a legacy or to charity ☐ support my family ☐ any purpose the beneficiary decides

2/ Build Cash value for: ☐ retirement savings ☐ to help pay future expenses of any kind

3/ Other purposes not identified above (please explain): ______________________________

____

Please provide any other information that you think may help us understand your financial situation and your ability to pay the Product premiums now and in the future:

____

____

____

____

Part B - Complete only if product selected under Transaction Type above is either SMART Universal Life or Advantage Plus II Whole Life

(In Part B, "you' and 'your' mean the Owner and 'Product' means the product selected in the Transaction Type section of this Form)

Your tax bracket is (select one): ☐ under 15% ☐ 15% to 28% ☐ > 28%

How many annuity or life insurance contracts have you replaced[1] within the past 36 months? _______

[1] See Appendix 11 Definition of Replacement.

If the answer to the above question is not zero, why was each annuity or life insurance contract replaced?

____

____

____

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____

____

Do you now own, or have you previously owned, any of the following: (check all that apply):
☐ Annuities ☐ Life Insurance ☐ Bonds ☐ Stocks ☐ CDs ☐ Checking/Savings account
☐ Retirement account ☐ Mutual Funds

If applying for SMART Universal Life, do you accept a surrender charge if you intend to withdraw from, or take a loan against, the Product cash value during the certificate surrender charge period?
☐ Yes ☐ No ☐ Not applicable as not applying for SMART UL

Are you willing to accept the Product non-guaranteed elements? ☐ Yes ☐ No

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Part C - Producer Statement Section (In Part C, ‘you’ and ‘I’ mean the Producer; “Transaction” and ‘Product’ are those selected in the Transaction Type section of this Form).

I believe this Transaction is suitable and in the best interest of the Owner based on the suitability information provided by the Owner and considering all other life insurance products that I am authorized to sell in New York for any insurer. ☐ Yes ☐ No

Please explain in as much detail as possible why you are recommending this Transaction to the Owner:

____

____

____

____

____

____

____

I have provided the Owner with Part D - Foresters Product Disclosure Summary page for the Product and discussed with the Owner each of the items listed on that page as it relates to this Transaction and other Product information relevant to the Owners situation and the potential consequences of this Transaction, both favorable and unfavorable.

☐ Yes ☐ No

Based on the Owners disclosed household income, assets and financial obligations I reasonably believe the Owner has the ability to make the premium payments in relation to this Transaction.

☐ Yes ☐ No

I have completed the Foresters product training for New York (505063 NY 03/20). ☐ Yes ☐ No

Print Producer Name: ______________________________ Producer number:________________

Signature of Producer: ________________________________ Date signed: ___________________

Owner/Applicant’s Statement and Signature (“Transaction” and ‘Product’ are those selected in the Transaction Type section of this Form; “Producer” is named in Part C)

I, the Owner: a) believe the information in Part A - Owner Suitability Information Section and in Part B (if completed) is accurate, b) confirm that the Producer explained to me why this Transaction is recommended as described in Part C c) confirm that the Producer discussed with me the information outlined in, and provided me with, Part D – Foresters Product Disclosure Summary page for the Product and d) I believe this Transaction is appropriate for my insurance needs based on my financial situation.

Owner signature: ________________________________ Date signed: ______________

Pages 1 to 3 of this Form must be completed, signed and submitted with the application for the Transaction. Part D of this form, for the Product, must be left with the Owner.

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Part D – Foresters Your Term Product Disclosure Summary

This page must be left with the Owner before the Owner signs the application for the Transaction.

“Certificate” in this Summary means the Your Term insurance contract, including its riders

- Your Term is renewable convertible term life insurance, available with initial term periods of 10, 15, 20, 25 or 30 years.
- This life insurance coverage, if not canceled or lapsed, continues to the end of the initial term period and thereafter is annually renewable to the insured’s age 100.
- Premiums are level during the initial term period and then increase annually at the beginning of each annual renewal period.
- Your Term is convertible, during the conversion period, to permanent life insurance without evidence of insurability.
- First premium payment is a requirement for coverage to come into effect.
- Premiums, after the first, must be paid on time. If not paid on time, the certificate will lapse subject to a grace period.
- Your Term has no cash value.
- There is an exclusion, and the benefit is not paid, if death is by suicide during the first two certificate years.
- Changes in coverage, such as increasing the face amount or adding a rider, cannot be done after the certificate issue date.
- Certificate may be reinstated within 3 years of lapse but cannot be reinstated if canceled.
- Reinstatement requires evidence of insurability.
- Your beneficiary can use the death benefit proceeds for any purpose.
- Your Term includes, for no additional premium, a Charity Benefit that provides, when the death benefit is payable, for an additional payment of up to 1% of the certificate’s face amount, up to $100,000, to an eligible charity of your choice if designated before the insured’s death.
- An Accelerated Death Benefit rider is included with each eligible Your Term certificate, for no additional premium. The Accelerated Death Benefit rider may provide a payment due to a diagnosis of a chronic, critical and/or terminal illness as defined in the rider. Which illnesses are included in this rider will be determined at time of underwriting. See the *Accelerated Death Benefit Rider Disclosure* provided to you for additional information such as the effect of the payment on the certificate including the face amount.
- Accidental Death, Children’s Term and Waiver of Premium riders can be included, subject to underwriting, for additional premium, to enhance the base life insurance coverage.
- Riders can end before the base life insurance coverage.

Note that this information is an overview of various product features and is not intended to modify the terms and conditions of the product. Refer to the Your Term certificate and each applicable rider for those terms and conditions.

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Part D – Foresters SMART UL Product Disclosure Summary

This page must be left with the Owner before the Owner signs the application for the Transaction.

"Certificate" in this Summary means the SMART UL insurance contract, including its riders

- SMART UL is a flexible premium adjustable life insurance product that can provide coverage for the life of the insured if not canceled, surrendered, terminated or lapsed. It has no maturity date.
- Payment of a first premium, at least equal to the minimum required premium, is a requirement for coverage to come into effect.
- Premiums, after the first, are flexible. Coverage will, subject to a grace period, stay in force as long as the cash value is sufficient to pay the monthly deductions or, during the first ten years, if the requirements of the minimum premium guarantee have been met.
- SMART UL has the potential to build cash value. Cash values are flexible and based, in part, on the amount and frequency of premiums paid, and the amount of interest credited.
- Interest is credited to the account value at the then current interest rate, which is guaranteed not to be less than 2.0%.
- The available cash value can be accessed through a loan or surrender. In some situations, the loan or surrender may be a taxable transaction.
- Surrenders may be subject to a surrender charge.
- If an outstanding certificate loan amount, including interest, exceeds the cash value, then the certificate will terminate. If not terminated, this amount is deducted from the death benefit payable.
- There is an exclusion, and the benefit is not paid, if death is by suicide during the first two certificate years.
- SMART UL coverage is adjustable meaning changes in coverage, such as increasing or decreasing the face amount, are allowed.
- Certificate may be reinstated within 3 years of lapse but cannot be reinstated if canceled, surrendered or terminated. Reinstatement requires evidence of insurability.
- Your beneficiary can use the death benefit proceeds for any purpose.
- SMART UL includes, for no additional monthly rider deduction, a Charity Benefit that provides, when the death benefit is payable, for an additional payment of up to 1% of the certificate's face amount, up to $100,000, to an eligible charity of your choice if designated before the insured's death.
- An Accelerated Death Benefit rider is automatically included with eligible SMART UL certificates, for no additional monthly rider deduction. The Accelerated Death Benefit rider may provide a payment due to a diagnosis of a chronic, critical and/or terminal illness as defined in the rider. Which illnesses are included in the rider will be determined at time of underwriting. See the *Accelerated Death Benefit Rider Disclosure* provided to you for additional information such as the effect of the payment on certificate values and amounts, such as the face amount.
- Accidental Death, Children's Term and Waiver of Monthly Deductions riders can be included, subject to underwriting, for an additional monthly rider deduction, to enhance the base life insurance coverage.
- Riders may end before the base coverage.

Note that this information is an overview of various product features and is not intended to modify the terms and conditions of the product. Refer to the SMART UL certificate and each applicable rider for those terms and conditions.

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Part D – Foresters Advantage Plus Product Disclosure Summary

This page must be left with the Owner before the Owner signs the application for the Transaction

“Certificate” in this Summary means the Advantage Plus II insurance contract, including its riders

- Advantage Plus II is whole life insurance providing coverage to the insured’s age 121 if not canceled, surrendered, terminated or lapsed. At age 121 the cash surrender value will be paid.
- First premium payment is a requirement for coverage to come into effect.
- Premiums do not increase with age. Premium must be paid on time. If not paid on time, the certificate may lapse subject to the Automatic Premium Loan (“APL”) provision, if elected, the applicable nonforfeiture option and a grace period.
- If APL is not elected, at the end of the grace period the certificate will convert to reduced paid-up life insurance unless the cash surrender option was selected in which case the cash surrender value will be paid to the certificate Owner.
- If electing APL, the available cash surrender value, if any, will be used to pay the unpaid premium due through a loan. Once the available cash surrender value is zero, the certificate is terminated.
- Advantage Plus II has guaranteed cash values that generally begin in the 2nd or 3rd certificate year and grow over time.
- Advantage Plus II is a participating product, which means it has the potential for dividends. These can purchase additional paid-up insurance and build additional cash value, be left on deposit to accumulate with interest, reduce premiums, or be paid in cash. Dividends are not guaranteed.
- The cash surrender value can be accessed through a loan or a full or partial surrender of coverage. In some situations, the loan or surrender may be a taxable transaction.
- If an outstanding certificate loan amount, including interest, exceeds the cash value plus the present value of paid-up additional insurance and the amount of dividends on deposit, then the certificate will terminate. If not terminated, this amount is deducted from the death benefit payable.
- There is an exclusion, and the benefit is not paid, if death is by suicide during the first two certificate years.
- Changes in coverage, such as increasing the face amount or adding a rider, cannot be done after the certificate issue date.
- Certificate may be reinstated within 3 years of lapse but cannot be reinstated if canceled, surrendered or terminated. Reinstatement requires evidence of insurability.
- Your beneficiary can use the death benefit proceeds for any purpose.
- Advantage Plus II includes, for no additional premium, a Charity Benefit that provides, when the death benefit is payable, for an additional payment of up to 1% of the certificate’s face amount, up to $100,000, to an eligible charity of your choice if designated before the insured’s death.
- An Accelerated Death Benefit rider is automatically included with eligible Advantage Plus II certificates, for no additional premium. The Accelerated Death Benefit rider may provide a payment due to a diagnosis of a chronic, critical and/or terminal illness as defined in the rider. Which illnesses are included in the rider will be determined at time of underwriting. See the *Accelerated Death Benefit Rider Disclosure* provided to you for additional information such as the effect of the payment on certificate values and amounts, such as the face amount.
- Accidental Death, Children’s Term, Waiver of Premium, Flexible and Single Payment Paid-up Additions, Guaranteed Insurability and Term riders can be included, subject to underwriting, for additional premium, to enhance the base life insurance coverage.
- Riders may end before the base coverage.

Note that this information is an overview of various product features and is not intended to modify the terms and conditions of the product. Refer to the Advantage Plus II certificate and each applicable rider for those terms and conditions.

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Suitability Additional Information & Waiver Form (New York Reg 187)

Part A (to be completed)

Name of Certificate Owner: _________________________ (first, middle, last) Certificate Number: ____________________ (if known)

Transaction Type (“Transaction”)**:**

□ New application to buy the product identified below
□ Reinstatement by Redate of the product identified below (not available for SMART Universal Life)

Product: □ Advantage Plus II Whole Life □ PlanRight □ SMART Universal Life □ Your Term

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Part B - Waiver Section (complete if Foresters was unable to determine that the Transaction was suitable but the Owner wishes to proceed with that Transaction anyway)

I, the proposed Owner, have applied for the above Transaction and although I understand that this Transaction has not been determined by Foresters to be suitable for me, and that I can explore other insurance coverage options, I wish to proceed with the Transaction anyway.

□ Yes □ No

Owner Signature: _________________________ Date Signed: _________________________

Part C - Additional Information Section (complete this section to provide additional information that was not previously provided in the Suitability and Best Interest Form)

I, the producer identified below, confirm that the following additional information was provided to me by the Owner and based on this additional information, and in the Suitability and Best Interest Form I previously signed, I believe this Transaction is suitable and in the best interest of the Owner considering all other life insurance products that I am authorized to sell in New York for any insurer.

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Print Producer Name: ______________________ Producer Signature: ______________________

Date Signed: _________________________

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