

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

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<b>Document Name</b>	<b>Description</b>	<b>Expiration Date</b>
770681-US-09-19-J	Application for Individual Life Insurance	12/31/2199
105370_WA	Illustration Certification	12/31/2199
104987_WA	Important Notice: Replacement Of Life Insuran...	12/31/2199
105690_US_b	1035 Exchange/Absolute Assignment Form	12/31/2199
106128-us-0420	COVID-19 Questionnaire. Not for use in CA, DE...	12/31/2199
409489 US 0320	Replacement Form Listing	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



### 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
<ul style="list-style-type: none"> <li>✓ Initialed all corrections (do not use white out), if any, and signed the Signature section (<i>Proposed insured and Owner</i>)</li> <li>✓ Signed and dated any supplemental sheets of paper (if required) (<i>Proposed insured and Owner</i>)</li> <li>✓ Initialed the TIA Acknowledgement (if pre-conditions not met) (<i>Owner only</i>)</li> </ul>	<ul style="list-style-type: none"> <li>✓ Signed the PAC Authorization (if applicable)</li> </ul>	<ul style="list-style-type: none"> <li>✓ Initialed all corrections, if any, and signed the Producer Certification section</li> <li>✓ Signed and dated any supplemental sheets of paper (if required)</li> </ul>
Send to Foresters	Leave with Owner	Leave with Proposed Insured
<ul style="list-style-type: none"> <li>✓ Completed application, the Product Details page and the Producer Report page</li> </ul> If applicable: <ul style="list-style-type: none"> <li>✓ First premium</li> <li>✓ Void check</li> <li>✓ Underwriting questionnaire(s)</li> <li>✓ State and Foresters replacement/rollover/surrender/disclosure forms</li> <li>✓ Completed Contingent Owner/Other Payer Identification form</li> <li>✓ Signed Illustration or illustration certification form</li> <li>✓ Notice and Consent for Blood and Body Fluid Testing (medically underwritten products)</li> </ul>	<ul style="list-style-type: none"> <li>✓ TIA Agreement (if pre-conditions are met)</li> <li>✓ Disclosure forms (e.g. Accelerated Death Benefit Rider Disclosure)</li> <li>✓ Buyer’s Guide</li> </ul> If applicable: <ul style="list-style-type: none"> <li>✓ State and Foresters replacement/rollover/surrender forms</li> <li>✓ Signed Illustration or illustration certification form</li> </ul>	<ul style="list-style-type: none"> <li>✓ Notices</li> </ul>

### 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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**Foresters**  
Financial

### Product Details (Complete and submit only if applying for term life insurance.)

#### Proposed Insured

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Last name: \_\_\_\_\_

#### Your Term Life

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

Non-medical

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

Medical

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

#### 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: \_\_\_\_\_

#### Riders (Subject to state and product availability.)

Accidental death:

\$ \_\_\_\_\_

Children's term:

\$ \_\_\_\_\_

Waiver of premium

Other rider(s): \_\_\_\_\_

#### Remarks:

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

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

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# The Independent Order of Foresters ("Foresters")

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

### Proposed Insured

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Last name: \_\_\_\_\_

### SMART Universal Life

(Each field in this section must be completed.)

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

Underwriting:  Non-medical  Medical

Planned premium: \$ \_\_\_\_\_  Monthly  Quarterly  Semi-annually  Annually

Life insurance qualification test:

Guideline Premium Test (GPT)

Cash Value Accumulation Test (CVAT)

Death benefit option:

Level

Increasing

Initial lump sum premium?  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: \_\_\_\_\_

### 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: \_\_\_\_\_

### Riders (Subject to state and product availability.)

Accidental death:

\$ \_\_\_\_\_

Children's term:

\$ \_\_\_\_\_

Guaranteed purchase option

Waiver of monthly deductions

Other rider(s): \_\_\_\_\_

Complete if the proposed insured is a juvenile.

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

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

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

### Remarks:

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

There may be additional Disclosure forms required before the certificate can be issued. Check the State requirements.

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**Foresters**  
Financial

### Product Details (Complete and submit only if applying for whole life insurance.)

#### Proposed Insured

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Last name: \_\_\_\_\_

#### Advantage Plus II Whole Life

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

Plan Type:  Paid-up at 100  20 Pay

Underwriting:  Non-medical  Medical

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

Automatic premium loan provision elected?  Yes  No

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

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

#### 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: \_\_\_\_\_

#### 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: \_\_\_\_\_

#### Complete if the proposed insured is a juvenile.

a) State amount of life insurance on primary caregiver: \$ \_\_\_\_\_

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

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

Remarks: \_\_\_\_\_

There may be additional Disclosure forms required before the certificate can be issued. Check the State requirements.

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### Application for Individual Life Insurance

Proposed Insured				
First name	Middle name	Last name	<input type="radio"/> Male <input type="radio"/> Female	
Street address		City	State	Zip
Social security #	Home phone #	Alternate phone/Cell #	Date of birth (mmm/dd/yyyy)	State & Country of birth
U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No. If "No", immigration status: <input type="radio"/> Green card holder <input type="radio"/> Permanent resident <input type="radio"/> Other (provide Visa type): _____				
Type of Photo I.D.: <input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government I.D.: _____				
Photo I.D. # (used to verify identity): _____				
Occupation & duties: _____				
<input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Seasonal		Income (past 12 months): \$ _____	Active duty military or reserves? <input type="radio"/> Yes <input type="radio"/> No	
Foresters member? <input type="radio"/> Yes <input type="radio"/> No, applying for membership.		Email	Primary language: <input type="radio"/> English <input type="radio"/> 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.: <input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> 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:	<input type="radio"/> Male <input type="radio"/> Female	Date of birth (mmm/dd/yyyy)	U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No. If "No", immigration status: <input type="radio"/> Green card holder <input type="radio"/> Permanent resident <input type="radio"/> Other (provide Visa type): _____	
Beneficiary (Each beneficiary below is revocable, unless "irrevocable" is written next to the name of that beneficiary.)				
			Date of birth (mmm/dd/yyyy)	Relationship to proposed insured
				% Share
Primary				
Name:				Total
Address:				
Name:				must equal
Address:				
Name:				100%
Address:				
Contingent				
Name:				Total must
Address:				
Name:				equal
Address:				100%
Financial Questions				
1. Is there an understanding or agreement, whether in writing or not, or has an offer been made to: <ul style="list-style-type: none"> <li>a) Borrow or be given money, or other property, to pay for or enter into the insurance contract applied for?</li> <li>b) Sell, transfer or assign an insurance contract issued as a result of this Application?</li> </ul> If "Yes" to 1a or 1b, provide details. _____				<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

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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.

<b>Lifestyle Questions</b>	
2. Within the past 12 months, have you used tobacco, in any form, or another nicotine product? If “Yes”, specify: <input type="radio"/> Cigarettes <input type="radio"/> Other	<input type="radio"/> Yes <input type="radio"/> 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? 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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? 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
6. Within the past 5 years, have you had your driver’s license suspended or revoked or been convicted of or pled guilty to more than 3 moving violations or to 1 or more driving while impaired or under the influence violations?	<input type="radio"/> Yes <input type="radio"/> No
7. a) Within the past 10 years, have you been convicted of or pled guilty to a felony? b) Are you currently on parole, incarcerated, or serving probation or within the past 12 months have you served probation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

**PART 1: Medical Questions**

8. Your: Height (ft/in): _____ Weight (lbs): _____	
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?	<input type="radio"/> Yes <input type="radio"/> No
10. Are you currently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> No
11. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> 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? 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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 any of the following activities of daily living: taking medications, bathing, dressing, eating, or toileting?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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 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)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No



**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 life, accidental death, critical illness or disability income insurance pending or in force?  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	Annuity/Life insurance \$	Accidental death \$	Critical illness \$	Disability income (per month) \$	Issue year or indicate if pending

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. Will coverage 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

**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 1<sup>st</sup> and 28<sup>th</sup>) 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 physician or medical practitioner, for chest pain, heart problem, stroke, cancer or AIDS (“Investigation” does not include negative tests for HIV)?	<input type="radio"/> Yes <input type="radio"/> 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)?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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 provided, authorized or collected. 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	<input type="radio"/> Male <input type="radio"/> 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 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, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. 6) Foresters will have no liability under an insurance contract issued, if any, as a result of this Application until the date that insurance contract comes into effect, according to its terms, and then only if (a) the first premium due, for that insurance contract, is provided in full on or before the delivery date of that insurance contract and is received by Foresters from the financial institution from which it is to be collected, and (b) between the date this Application was signed and the date that insurance contract comes into effect there is no event, no diagnosed change in health, and no change in the habits or circumstances of the proposed insured, or a child if any, identified in this Application, that would require a change to an answer to a question in this Application. 7) Foresters and its subsidiaries may review, transfer and otherwise use, information provided in this Application or obtained by Foresters or its subsidiaries to assess, develop, or offer and issue to me (including post issue administration), other financial products or benefits. 8) Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identity.

I further understand and agree that: 1) Changes or corrections made to this Application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. Such changes or corrections may be made directly on this Application or by an amendment to this Application. 2) No producer, medical examiner or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to make, modify, or discharge an insurance contract. 3) This Application and related documents may be completed, signed and/or submitted to Foresters by voice and/or electronic means and if completed in paper form this original Application may be destroyed after confirmation of successful transmission. 4) Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 5) 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) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

### Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims, (c) supporting The Independent Order of Foresters ("Foresters") business analysis and operations and (d) record keeping and future servicing by authorized persons. In this authorization, "proposed insured", "owner" and "parent/legal guardian" mean each person identified as such in this Application. "Child" means 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 drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. Information may be disclosed: between and among Foresters and authorized persons; to companies to which the proposed insured has or may apply to for insurance coverage or benefits; as required or permitted by law. The proposed insured, and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons, to make a brief report of the proposed insured's and each child's personal and/or protected health information to MIB, even if this Application is cancelled or withdrawn. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this Application. This time limit complies with the time limit, if any, permitted by the applicable law in the state where the certificate is delivered or issued for delivery. A copy of this authorization shall be as valid as the original. Each person signing this authorization may at any time, by written notice to Foresters, revoke their authorization, except that reporting to MIB and action(s) begun before receipt of notice will not be affected. A Notices page has been provided, 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.)

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 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 negative tests for HIV)?	<input type="radio"/> Yes <input type="radio"/> 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)?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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 or oral request to cancel or withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 6) The date written notice is sent by us, as shown in our records, to the owner, terminating this Agreement, cancelling or declining the Application.

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

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

**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

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

## **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.

### **Benefit Description**

The rider provides the opportunity for the owner to accelerate a portion of the certificate’s eligible death benefit (“acceleration amount”), during the lifetime of the insured, and receive an accelerated death benefit payment (“payment”). Under the conditions described in the rider the owner may elect to receive a payment if the insured is diagnosed, by a physician, with a chronic, critical or terminal illness, as applicable under that rider. The payment is paid to the owner and not to the beneficiary(ies). A claim made during the contestable period may result in cancellation of the insurance contract, with no benefit being paid. The rider is not, and is not intended to be, long-term care insurance.

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

Chronic illness means the insured:

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

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

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

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

### **Amount of the Accelerated Death Benefit Payment**

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

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

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

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

### Effect of Payment on the Certificate

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

### 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.

### 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, with 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

	<u>Before Acceleration</u>	<u>After Acceleration</u>		
		<u>Chronic Illness</u>	<u>Critical Illness</u>	<u>Terminal Illness</u>
<b>Face Amount:</b>	\$ 200,000.00	\$ 152,000.00	\$ 10,000.00	\$ 10,000.00
<b>Annual Premium:</b>	\$ 984.00	\$ 764.64	\$ 115.70	\$ 115.70

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

	<u>Chronic Illness</u>	<u>Critical Illness</u>	<u>Terminal Illness</u>
<b>Acceleration Amount:</b>	\$ 48,000.00	\$ 190,000.00	\$ 190,000.00
<b>Payment Percentage:</b>	15.022 %	15.022 %	100.00 %
<b>Gross Payment Amount:</b>	\$ 7,210.56	\$ 28,541.80	\$ 190,000.00
minus <b>Administrative Fee:</b>	\$ 300.00	\$ 300.00	\$ 0.00
minus <b>Overdue Premium:</b>	\$ 0.00	\$ 0.00	\$ 0.00
<b>Accelerated Death Benefit Payment:</b>	\$ 6,910.56	\$ 28,241.80	\$ 190,000.00

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.

<b>Year</b>	<b>Acceleration Amount</b>	<b>Accelerated Death Benefit Payment</b>	<b>Year</b>	<b>Acceleration Amount</b>	<b>Accelerated Death Benefit Payment</b>
2	\$190,000.00	\$ 18,383.71	15	\$190,000.00	\$ 32,714.44
5	\$190,000.00	\$ 22,301.09	20	\$190,000.00	\$ 34,996.29
7	\$190,000.00	\$ 24,814.62	25	\$190,000.00	\$ 29,112.53

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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Financial

### 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. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for AIDS information.

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

## Producer Report

### Proposed Insured

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Last name: \_\_\_\_\_

Producer's name	Producer #	% of split

- 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.
- Should the certificate's issue date be adjusted to save the insurance age?  
If "Yes", additional premium may be required.  Yes  No
- Is the proposed insured you, your spouse/partner or your child/stepchild?  Yes  No
- In the Application, are you the owner, payer or beneficiary?  Yes  No
- 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
- Was a copy of the Buyer's Guide provided to the owner at the time of sale?  Yes  No
- 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

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### Illustration Certification

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

Proposed Insured's Name: \_\_\_\_\_ Plan Applied For: \_\_\_\_\_

Prospective Owner's Name: \_\_\_\_\_ Producer's Name: \_\_\_\_\_  
(if other than proposed insured)

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

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

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

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

<b>Plan Applied For:</b>		<b>Face Amount: \$</b>	
<b>Premium Amount: \$</b>	<b>Premium Mode:</b> <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Annually		
<b>Number of Years Premium Assumed to be Paid:</b>		<b>Number of Years Illustrated:</b>	
<b>Sex:</b> <input type="radio"/> Male <input type="radio"/> Female	<b>Issue Age:</b>	<b>Insurance Class:</b> <input type="radio"/> Tobacco <input type="radio"/> Non-Tobacco	
<b>Dividend Option:</b> <input type="radio"/> Paid-up additions <input type="radio"/> Paid in cash <input type="radio"/> Left on deposit <input type="radio"/> To reduce premiums			
<b>Rider(s) (name and benefit amount):</b>			

#### Universal Life Only

<b>Death Benefit:</b> <input type="radio"/> Level <input type="radio"/> Increasing	<b>Guaranteed Interest Rate:</b> %	<b>Current Interest Rate (Non-Guaranteed):</b> %
<b>Life Insurance Qualification Test:</b> <input type="radio"/> Guideline Premium Test (GPT) <input type="radio"/> Cash Value Accumulation Test (CVAT)		

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

\_\_\_\_\_  
Producer's Signature

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

### Prospective Owner's Certification

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

# 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



### Illustration Certification

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

Proposed Insured's Name: \_\_\_\_\_ Plan Applied For: \_\_\_\_\_

Prospective Owner's Name: \_\_\_\_\_ Producer's Name: \_\_\_\_\_  
(if other than proposed insured)

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

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

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

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

<b>Plan Applied For:</b>		<b>Face Amount: \$</b>	
<b>Premium Amount: \$</b>	<b>Premium Mode:</b> <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Annually		
<b>Number of Years Premium Assumed to be Paid:</b>		<b>Number of Years Illustrated:</b>	
<b>Sex:</b> <input type="radio"/> Male <input type="radio"/> Female	<b>Issue Age:</b>	<b>Insurance Class:</b> <input type="radio"/> Tobacco <input type="radio"/> Non-Tobacco	
<b>Dividend Option:</b> <input type="radio"/> Paid-up additions <input type="radio"/> Paid in cash <input type="radio"/> Left on deposit <input type="radio"/> To reduce premiums			
<b>Rider(s) (name and benefit amount):</b>			

#### Universal Life Only

<b>Death Benefit:</b> <input type="radio"/> Level <input type="radio"/> Increasing	<b>Guaranteed Interest Rate:</b> %	<b>Current Interest Rate (Non-Guaranteed):</b> %
<b>Life Insurance Qualification Test:</b> <input type="radio"/> Guideline Premium Test (GPT) <input type="radio"/> Cash Value Accumulation Test (CVAT)		

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

\_\_\_\_\_  
Producer's Signature

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

### Prospective Owner's Certification

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

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

(Save this notice! It may be important to you in the future)

The decision to buy a new life insurance policy or contract or annuity and discontinue or change an existing one is very important. Your decision could be a good one or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

**STATEMENT TO APPLICANT BY PRODUCER OR BROKER**

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes, explain:
2. Are there penalties, set up or surrender charges for the new policy or contract?  No  Yes, explain, emphasizing any extra cost for early withdrawal:
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  No  Yes, explain:
4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes, explain:
5. a) Are interest earnings a consideration in this replacement?  No  Yes  
b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy or contract fees, and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes, explain:
7. If the new program is based on a variable or universal life insurance policy or contract or a single-premium policy or contract or annuity:
  - a) Are the interest rates quoted before \_\_\_\_\_ or after \_\_\_\_\_ fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_
  - c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is \_\_\_\_\_ and the limit on the amount that can be borrowed is \_\_\_\_\_

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

(Save this notice! It may be important to you in the future)

The decision to buy a new life insurance policy or contract or annuity and discontinue or change an existing one is very important. Your decision could be a good one or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

**STATEMENT TO APPLICANT BY PRODUCER OR BROKER**

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes, explain:
2. Are there penalties, set up or surrender charges for the new policy or contract?  No  Yes, explain, emphasizing any extra cost for early withdrawal:
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  No  Yes, explain:
4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes, explain:
5. a) Are interest earnings a consideration in this replacement?  No  Yes  
b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy or contract fees, and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes, explain:
7. If the new program is based on a variable or universal life insurance policy or contract or a single-premium policy or contract or annuity:
  - a) Are the interest rates quoted before \_\_\_\_\_ or after \_\_\_\_\_ fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_
  - c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is \_\_\_\_\_ and the limit on the amount that can be borrowed is \_\_\_\_\_

e) The surrender charges are \_\_\_\_\_

f) The death benefit is \_\_\_\_\_

8. Are there other short or long term effects from the replacement that might be materially adverse?  
 No  Yes, explain:

\_\_\_\_\_  
SIGNATURE OF PRODUCER OR BROKER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF PRODUCER OR BROKER  
(Print or Type)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADDRESS

List of Policies or Contracts to be replaced:

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

CAUTION: The insurance commissioner suggests you consider these points:

Usually, contestable and suicide periods start again under a new policy or contract. Benefits might be excluded under a new policy or contract that would be paid under existing insurance.

Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.

You are entitled to advice from the existing producer or company. Such advice might be helpful.

Study the comments made above by the producer or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY OR CONTRACT.

e) The surrender charges are \_\_\_\_\_

f) The death benefit is \_\_\_\_\_

8. Are there other short or long term effects from the replacement that might be materially adverse?  
 No  Yes, explain:

\_\_\_\_\_  
SIGNATURE OF PRODUCER OR BROKER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF PRODUCER OR BROKER  
(Print or Type)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADDRESS

List of Policies or Contracts to be replaced:

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

CAUTION: The insurance commissioner suggests you consider these points:

Usually, contestable and suicide periods start again under a new policy or contract. Benefits might be excluded under a new policy or contract that would be paid under existing insurance.

Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.

You are entitled to advice from the existing producer or company. Such advice might be helpful.

Study the comments made above by the producer or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY OR CONTRACT.

# The Independent Order of Foresters ("Foresters")

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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
	<input type="radio"/> Attached <input type="radio"/> Lost/Destroyed		<input type="radio"/> Attached <input type="radio"/> Lost/Destroyed
	<input type="radio"/> Attached <input type="radio"/> Lost/Destroyed		<input type="radio"/> Attached <input type="radio"/> 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.

**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:** \_\_\_\_\_

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**COVID-19 (Coronavirus) Questionnaire**

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

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

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

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

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

- Yes
- No

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

- Yes
- No

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

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

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

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

- Yes
- No

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

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

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

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

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

## LIFE INSURANCE REPLACEMENT FORM REQUIREMENTS & FREE LOOK PERIODS

- The replacement form requirements outlined below **do not** apply if the Insured has NO existing individual coverage.

State	Replacement Free Look <sup>1</sup>	Insured has existing coverage but does <b>NOT</b> intend to replace it	Insured has existing coverage <b>AND</b> intends to replace it
Alabama	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Alaska			
Arizona			
Arkansas	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> <li>Life Insurance and Annuities Replacement Memorandum 105103 AR 11/09</li> </ul>
California	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> <li>Notice to Applicant Replacement Form 105921 CA 03/20 (Use for replacements to non-PlanRight only)</li> </ul>
Colorado	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Connecticut			
Delaware	20 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>
District of Columbia	30 days	No form(s) required	
Florida	20 days	No form(s) required	<ul style="list-style-type: none"> <li>FL – Important Notice: Replacement of Life Insurance or Annuities 104989 FL 07/08</li> <li>If the applicant elects to have the FL-Comparative Information Form, it will be completed in-house at Foresters™ and sent to the applicant directly. No producer action is required.</li> <li>FL – Certificate Disclosure Form and Instructions 105821 FL 07/18 (Internal Replacements only)</li> </ul>
Georgia	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>

<sup>1</sup> Free Look for Foresters PlanRight reduced death benefit plans (called Graded, Modified, and Basic) is:

- New Business: 30 days for all states
- Replacements: greater of 30 days or the state-specific replacement period shown in above chart.

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## LIFE INSURANCE REPLACEMENT FORM REQUIREMENTS & FREE LOOK PERIODS

• The replacement form requirements outlined below do not apply if the Insured has NO existing individual coverage.

State	Replacement Free Look <sup>1</sup>	Insured has existing coverage but does <b>NOT</b> intend to replace it	Insured has existing coverage <b>AND</b> intends to replace it
Hawaii	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Idaho	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>
Illinois	30 days	No form(s) required	<ul style="list-style-type: none"> <li>IL Important Notice: Replacement of Life Insurance or Annuities 105024 IL 09/08</li> </ul>
Indiana	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>
Iowa	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Kansas	30 days	No form(s) required	<ul style="list-style-type: none"> <li>KS – Important Notice: Replacement of Life Insurance or Annuities (different companies) 104980 KS 05/09; <b>or</b></li> <li>KS – Important Notice: Replacement of Life Insurance or Annuities (same company) 104981 KS 05/09</li> <li>KS-Comparative Information form 105750 KS 11/12 (Internal Replacements Only)</li> </ul>
Kentucky	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Louisiana			
Maine			
Maryland			
Massachusetts	30 days	No form(s) required	<ul style="list-style-type: none"> <li>MA – Important Notice: Replacement of Life Insurance or Annuities 104982 MA 07/08</li> </ul>
Michigan	30 days	No form(s) required	<ul style="list-style-type: none"> <li>MI – Important Notice: Replacement of Life Insurance or Annuities 104983 MI 07/08;</li> <li>MI – Information Statement 104984 MI 07/08</li> </ul>

<sup>1</sup> Free Look for Foresters PlanRight reduced death benefit plans (called Graded, Modified, and Basic) is:

- New Business: 30 days for all states
- Replacements: greater of 30 days or the state-specific replacement period shown in above chart.

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## LIFE INSURANCE REPLACEMENT FORM REQUIREMENTS & FREE LOOK PERIODS

• The replacement form requirements outlined below **do not** apply if the Insured has **NO** existing individual coverage.

State	Replacement Free Look <sup>1</sup>	Insured has existing coverage but does <b>NOT</b> intend to replace it	Insured has existing coverage <b>AND</b> intends to replace it
Minnesota	30 days	No form(s) required	<ul style="list-style-type: none"> <li>MN – Important Notice 105927 MN 06/16</li> </ul>
Mississippi	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Missouri	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Montana	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Nebraska	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/0</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Nevada	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>
New Hampshire	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
New Jersey			
New Mexico			

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## LIFE INSURANCE REPLACEMENT FORM REQUIREMENTS & FREE LOOK PERIODS

- The replacement form requirements outlined below **do not** apply if the Insured has NO existing individual coverage.

State	Replacement Free Look <sup>1</sup>	Insured has existing coverage but does <b>NOT</b> intend to replace it	Insured has existing coverage <b>AND</b> intends to replace it
New York	60 days	<p>ALL New York applications (regardless of whether the insured has existing coverage or not)</p> <ul style="list-style-type: none"> <li>Appendix 11 – Definition of Replacement 105006 NY (04/09)</li> </ul>	<p>ALL New York Applications (regardless of whether the insured has existing coverage or not)</p> <ul style="list-style-type: none"> <li>Appendix 11 – Definition of Replacement 105006 NY (04/09)</li> </ul> <p>PLUS: If there is an intention to replace existing life insurance or an annuity complete:</p> <ul style="list-style-type: none"> <li>Appendix 10C – Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts 105003 NY (04/09)</li> <li>Appendix 10A – Disclosure Statement 105004 NY (04/09)</li> <li>Authorization &amp; Direction to Release Information 105007 NY (06/11)</li> </ul> <p>OR: IF there is an intention to replace existing long-term care, nursing home or home care insurance:</p> <ul style="list-style-type: none"> <li>Notice to Applicant Regarding Replacement of Accident and Health Insurance and the Purchase of Multiple Accident and Health Policies 105922 NY (01/16)</li> </ul> <p>OR: IF there is an intention to replace existing life insurance that allows for the acceleration of the death benefit due to chronic illness:</p> <ul style="list-style-type: none"> <li>Appendix 10C – Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts 105003 NY (04/09)</li> <li>Appendix 10A – Disclosure Statement 105004 NY (04/09)</li> <li>Authorization &amp; Direction to Release Information 105007 NY (06/11)</li> <li>Notice to Applicant Regarding Replacement of Accident and Health Insurance and the Purchase of Multiple Accident and Health Policies 105922 NY (01/16)</li> </ul>
North Carolina	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
North Dakota	20 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>
Ohio	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>

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## LIFE INSURANCE REPLACEMENT FORM REQUIREMENTS & FREE LOOK PERIODS

- The replacement form requirements outlined below **do not** apply if the Insured has **NO** existing individual coverage.

State	Replacement Free Look <sup>1</sup>	Insured has existing coverage but does <b>NOT</b> intend to replace it	Insured has existing coverage <b>AND</b> intends to replace it
Oklahoma	30 days	No form(s) required	<ul style="list-style-type: none"> <li>OK - Important Notice: Replacement of Life Insurance or Annuities 104985 OK 01/13</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Oregon	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Pennsylvania	45 days	No form(s) required	<ul style="list-style-type: none"> <li>PA - Important Notice: Replacement of Life Insurance or Annuities 104991 PA 07/08</li> </ul>
Rhode Island	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
South Carolina			
South Dakota			
Tennessee	30 days	No form(s) required	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>
Texas	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Utah	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Vermont			
Virginia			
Washington	30 days	No form(s) required	<ul style="list-style-type: none"> <li>WA – Important Notice: Replacement of Life Insurance or Annuities 104987 WA 07/08</li> </ul>
West Virginia	30 days	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08</li> </ul>	<ul style="list-style-type: none"> <li>NAIC Important Notice: Replacement of Life Insurance or Annuities 104978 US 06/08;</li> <li>Producer Certification: Sales Materials Used in Replacement 102129 US 06/08</li> </ul>
Wisconsin			
Wyoming	30 days	No form(s) required	<ul style="list-style-type: none"> <li>Replacement Notice 105786 WY 02/13</li> </ul>

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