The Independent Order of Foresters ("Foresters") - **A Fraternal Benefit Society.**
789 Don Mills Road, Toronto, Canada M3C 1T9
U.S. Mailing Address: P.O. Box 179, Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Foresters

Application for Individual Life Insurance

1. Proposed Insured (Full legal name)

First name	Middle name	Last name
John	Chris	Doe

Street address	City	State	Zip code	E-mail Address (optional)
123 Mackenzie Drive	Dearborn	MI	48185	

Home phone #	Alternate phone/Cell #	Date of birth (mmm/dd/yyyy)	State & Country of birth	Social security #
712-734-3434		Feb/06/1949	MI & USA	1234-56-789

Sex:	Height / Weight	Used tobacco or nicotine in any form within the past 12 months?	Foresters member?
⊗ Male ○ Female	5'11/185	○ Yes ⊗ No	○ Yes ⊗ No, applying for membership.

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

Part A. If a "Yes" answer in Part A, the proposed insured is not eligible for Foresters PlanRight. Do not complete or submit this Application.

1. Are you currently: a resident in a nursing home or skilled nursing facility; a patient in a hospital or psychiatric facility; receiving, or have been advised to receive, skilled nursing care, hospice care, or home healthcare; confined to a correctional facility? ○ Yes ⊗ No
2. Do you require a wheelchair due to a chronic illness or disease, or do you require assistance (from anyone) with activities of daily living such as taking medications, bathing, dressing, eating, or toileting? ○ Yes ⊗ No
3. Within the past 12 months, have you:
   a) Used, or been advised to use, oxygen equipment to assist with breathing (excluding use for sleep apnea) or had, or been advised to have, kidney dialysis? ○ Yes ⊗ No
   b) Been advised to have surgery, hospitalization or a diagnostic test (excluding tests related to the Human Immunodeficiency Virus (HIV)) which has not yet been started, completed, or for which results are not known? ○ Yes ⊗ No
4. Have you ever received, or been advised to receive, an organ or bone marrow transplant, or had an amputation due to complications of diabetes? ○ Yes ⊗ No
5. Have you ever been diagnosed with, or received or been advised to receive treatment or medication for:
   a) Amyotrophic Lateral Sclerosis (ALS), congestive heart failure, or any terminal illness or end-stage disease? ○ Yes ⊗ No
   b) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? ○ Yes ⊗ No
   c) Alzheimer's disease or dementia, or been prescribed: Aricept, Cognex, Donepezil, Exelon, Razadyne, or Namenda? ○ Yes ⊗ No
6. Have you ever had or been diagnosed with more than one occurrence of the same or different type of cancer; or do you currently have cancer (excluding basal cell skin cancer)? ○ Yes ⊗ No

If all "No" answers in Part A, complete Part B.

Part B. Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.

1. Within the past 2 years have you had, or been diagnosed with, or received or been advised to receive treatment or medication for:
   a) Alcohol or drug abuse, or have you used illegal drugs? ○ Yes ⊗ No
   b) Complications of diabetes such as: diabetic coma, insulin shock, retinopathy (eye), nephropathy (kidney), or neuropathy (nerve, circulatory)? ○ Yes ⊗ No
2. Within the past 2 years have you had, or been diagnosed with:
   a) Angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory surgery? ○ Yes ⊗ No
   b) Stroke or Transient Ischemic Attack (TIA/mini-stroke)? ○ Yes ⊗ No
   c) Brain tumor or aneurysm? ○ Yes ⊗ No
3. Within the past 3 years have you had or been diagnosed with cancer, or received or been advised to receive chemotherapy or radiation for cancer (the term "cancer" excludes basal cell skin cancer)? ○ Yes ⊗ No

If a "Yes" answer in Part B, select Foresters PlanRight (With a modified death benefit) in Section 4. If all "No" answers, complete Part C.

Part C. Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.

1. Have you ever had, or been diagnosed with, or received or been advised to receive treatment or medication for:
   a) Parkinson's disease or Systemic Lupus (SLE)? ○ Yes ⊗ No
   b) Liver or kidney disease or condition (such as chronic hepatitis or cirrhosis of the liver)? ○ Yes ⊗ No
   c) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, or emphysema? ○ Yes ⊗ No

If a "Yes" answer in Part C, select Foresters PlanRight (With a graded death benefit) in Section 4. If all "No" answers, select Foresters PlanRight (With a level death benefit) in Section 4.

3. Other Insurance and Financial Questions

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

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

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

4. Insurance Applied For

Certificate type: ⊗ Foresters PlanRight (With a level death benefit.) ○ Foresters PlanRight (With a graded death benefit.) ○ Foresters PlanRight (With a modified death benefit.)

Insurance amount: $ 25,000 **Premium amount:** (based on payment mode) $ 134.73

Additional coverage: ⊗ Accidental Death Rider (only if selecting Foresters PlanRight (With a level death benefit)) $ 25,000

○ Other: _____

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

Automatic premium loan provision elected? *("Yes" or "No" must be indicated)* ⊗ Yes ○ No

If "Yes", overdue premium will be paid through a loan against, and for as long as there is, available cash value, if any. If "No", the certificate's Nonforfeiture provision will automatically apply, if premium is overdue at the end of the grace period, resulting in either reduced coverage or surrender.

5. Payment Information

Payer is: ⊗ Proposed insured ○ Owner (if other than proposed insured) ○ Other (complete Payer ID Form)

First premium payment provided by: ⊗ Pre-Authorized Check (PAC) (complete Payment Form) ○ Check ○ Other (complete Payment Form)

Subsequent premium payments made by: ⊗ Pre-Authorized Check (PAC) (complete Payment Form) ○ Direct bill ○ Other (complete Payment Form)

Payment mode: ⊗ Monthly (PAC only) ○ Quarterly ○ Semi-annually ○ Annually

Is a specific draft date being requested? ⊗ No

○ Yes, draft on the ____ day (choose between 1st and 28th) of the month, beginning in ____ (month).

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

6. Beneficiary Information (Each beneficiary below is revocable. If, however, a beneficiary is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary.)

Full legal name, home phone # and address (street, city, state, zip code) of each primary beneficiary.		Relationship to proposed insured	% Share
Name Susan Doe	Home phone # 712-734-3434	Spouse	Total must equal 100%
Address 123 Mackenzie Drive, Dearborn, MI 48185			
Name	Home phone #		
Address			
Name	Home phone #		
Address			
Full legal name, home phone # and address (street, city, state, zip code) of each contingent beneficiary.		**Relationship to proposed insured**	**% Share**
Name Jack Doe	Home phone # 712-734-3435	Son	Total must equal 100%
Address 12 Mill Street, Dearborn, MI 48179			
Name	Home phone #		
Address			

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

Full legal name of Individual (First, Middle, Last), Institution or Trust				
Street address		City	State	Zip code
Home phone #	Alternate phone/Cell #	E-mail Address (optional)	Social security /Tax ID #	
Relationship to the proposed insured		If individual: Sex ○ Male ○ Female	Date of birth (mmm/dd/yyyy):	

8. Agreements

I, the proposed insured and/or owner, declare that I have reviewed all of the statements and answers as they pertain to me and that they are true and complete to the best of my knowledge and belief. The statements and answers in this application are the basis for an insurance contract (defined as a certificate and each rider attached to that certificate), if any, issued by Foresters. No information about me will be considered to have been given to Foresters by me unless it is stated in this application. A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. 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. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. Foresters will have no liability until an insurance contract is issued based on this application, the first premium due is paid in full on or before the delivery date of that insurance contract, and provided that there has been no change in either an answer to an application question or the proposed insured's health or habits between the date this application was signed and the issue date of that insurance contract. Changes or corrections made to this application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. This application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently enacted, shall form part of the entire contract with Foresters. This application and related documents may be sent by electronic means. Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this application or number(s) that I later provide. If I have chosen to provide an email address in this application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. Foresters may review, transfer and otherwise use, information provided in this application to offer and issue (including post issue administration), other insurance products to me. Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identification. 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.

9. Authorization To Obtain And Disclose Information

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

10. Signature Section (For purposes of sections 1 to 9. Review entire Application before signing.)

X John Doe — Proposed insured's signature
Signed on: May/01/2014 — Date (mmm/dd/yyyy)
Signed at: Dearborn, MI — (City, State)

X _____ — Owner's signature (if other than the Proposed Insured)
Signed on: _____ — Date (mmm/dd/yyyy)
Signed at: _____ — (City, State)

11. Producer Certification

I certify the following: I am not aware of undisclosed information about the health, habits, or lifestyle of the proposed insured that might affect insurability. I complied with applicable regulatory requirements including those relating to the solicitation and sale of life insurance to active duty members of the United States military. All questions, to which an answer is shown, were asked as written in this application. The answers given by the proposed insured were recorded as shown and this application was reviewed with him/her before it was signed.

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

Producer's full name: Foresters Producer
Producer's signature: X Foresters Producer

Producer number: 000000
Date (mmm/dd/yyyy): May/01/2014

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Payment Information Form

Billing and Payment Information

Proposed Insured: First Name: John Last Name: Doe

Date of birth (mmm/dd/yyyy): Feb/06/1949

Reference/certificate number (if available): _____

Payer is: ☒ Proposed Insured ○ Owner ○ Other (complete Payer ID form)

PAC Banking Information to be taken from:

☒ Checking Account (attach void check below) ○ Savings Account (complete below) ○ From check submitted with the application

Please:
1) Attach void check here
OR
2) Provide the following banking information (please print):

Name of financial institution: ABC Bank

Street Address: 123 Bank Street

City: Dearborn **State:** MI **Zip Code:** 48185

Transit Number: 123456789 **Account Number:** 1234597890

By signing below, I, as payer, verify that I am the account holder of the account identified in this Payment Information Form and I am permitted to provide this authorization, and agree that: 1) Foresters is authorized to draft deductions under the PAC selection(s) made in the application in relation to the above named Proposed Insured, from that account or another account later identified or substituted by me. 2) The financial institution from which payments are to be drafted is authorized to treat each draft by Foresters as though it was made personally by me. 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 according to the coverage(s) and certificate type issued. 4) The PAC plan is effective immediately and will continue until terminated, which either Foresters or I may do at any time by written notice to the other.

John Doe
Printed name of payer

X John Doe
Signature of payer

Signed on: May/01/2014
Date (mmm/dd/yyyy)

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

For purposes of these Notices the following words are defined: "Application" means the Application for Individual Life Insurance to which this Notice relates; "Producer" means the licensed individual who signed that Application as the producer; "Foresters", "we", "our", and "us" mean The Independent Order of Foresters; "You" and "your" mean the proposed insured. If you have questions, discuss them with your producer or contact us directly. Write to Foresters, Chief Underwriter 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, we may disclose information without further authorization to insurance companies to which you have applied for coverage or benefits, those providing services for us and those conducting bona fide actuarial, marketing or scientific studies or audits. We may also disclose information to your physician and MIB, Inc. ("MIB"). You can make a written request to review personal information about you in our file. However, we will not disclose information to you that was prepared for an anticipated claim, civil or criminal proceeding. You may request correction of information which you believe to be inaccurate or irrelevant. Upon written request, we will provide more information about these procedures.

Medical and Personal Information - The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. 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 its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 Park, Suite 400, Braintree, Massachusetts 02184-8734. Foresters, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Website at www.mib.com.

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Acknowledgement of First Premium (This section must be given to the owner.)

It is acknowledged that an amount of $ 134.73 was provided to be applied as the first premium payment for the certificate issued, if any, in response to the Application for Individual Life insurance on the life of John Doe .

Proposed insured's name.

This amount will be refunded, if collected by us, if no certificate is issued. The first premium amount may be adjusted based on the certificate type issued.

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

Insurance will only come into effect on the issue date of the certificate issued, if any, and subject to the terms of that certificate, provided a) that first premium payment is honored when presented to the financial institution from which it is to be collected, and b) that there has been no change in either an answer to an application question or the proposed insured's health or habits between the date the application was signed and the issue date of that insurance contract.

Producer's signature: **X** Foresters Producer Date (mmm/dd/yyyy) May/01/2014

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Producer Report *(Required)*

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

Producer:
Name: Foresters Producer Number: 000000

Proposed insured:
First Name: John Last Name: Doe Date of birth (mmm/dd/yyyy): Feb/06/1949

1. How long have you known the proposed insured? 2 Years
2. Are you related to the proposed insured? ○ Yes ⊗ No
   If 'Yes', what is the relationship? _____
3. a) At the time the Application was taken, did you see the proposed insured? ⊗ Yes ○ No
   b) Did you personally interview and complete the Application in the presence of the proposed insured? ⊗ Yes ○ No
   If 'No' to either a or b, explain in Remarks below.
4. Did you personally witness each signature in the Application? ⊗ Yes ○ No
   If 'No', identify and provide contact information of person who obtained and witnessed the signature(s).
   _____
5. Did you personally review each document used to verify identity and birth date? ⊗ Yes ○ No
   If 'No', identify and provide contact information of person who reviewed each document (if different than the person identified in question 4.)
   _____
6. A personal health interview (PHI) must be conducted as part of the application process. Provide the PHI Inspection Reference ID number. # 1234567
7. Upon completion of the PHI, did the interviewer confirm eligibility for the certificate type selected? ⊗ Yes ○ No
   If 'No', were changes to the Application made and initialed, and a new page 3 signed, in both sections 10 & 11, as required? ○ Yes ○ No
8. Did you review and leave the Acknowledgement of First Premium with the owner? ⊗ Yes ○ No
9. Proposed insured's primary language is ⊗ English ○ Spanish ○ Other _____
10. Number of people under 25 years of age living in the proposed insured's household? _____
11. Was a copy of the Buyer's Guide provided to the owner at the time of sale? ⊗ Yes ○ No
12. Are the commissions to be split with another producer? ○ Yes ⊗ No
    If 'Yes', state what the percentage should be for the producer who filled out this Application: _____%
    Name and producer number of producer who will receive the remaining percentage: _____

Note: If the proposed insured has had life insurance with Foresters that was in force within the last 13 months, this will be considered an internal replacement and will affect compensation.

Certificate Issuing Instructions

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

The certificate should be: ⊗ Mailed directly to owner. ○ Sent to Producer for delivery.

Remarks