

The Independent Order of Foresters ("Foresters")

Tips for Submitting a Foresters Paper Application for Individual Life Insurance

Foresters Fraternal Difference

- Foresters shares its financial strength with its members by offering them more than just a financial product; eligible members also benefit from member benefits and community involvement opportunities to help them and their families get more out of life. Use the Foresters Benefit of Membership pamphlet to share the Foresters story and make a difference.
- 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.

How to Avoid Delays and Get PAID Fast

- Money orders or cashier's checks are not permitted for the payment of initial premiums.
- 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.
- Available questionnaires are listed in the Producer Report. We may require additional information for each "Yes" answer in the Lifestyle and Medical Questions sections. You can help 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.
- 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.
- Premium payments cannot be made by the producer (unless the proposed insured is the producer or a dependent of the producer).
- If submitting an application through the POS process, refer to the POS Reference Guide on Foresters producer website for instructions.

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

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

Questions? Go to Foresters producer website (foresters.com/Agent Login)

The Independent Order of Foresters ("Foresters")

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

Proposed Insured

First name: _____ Middle name: _____ Last name: _____

Lifefirst Term Life

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

Term: 10 year 20 year 25 year 30 year

Riders (Subject to state and product availability.)

Disability income (accident and sickness): \$ _____ OR Disability income (accident only): \$ _____

If Disability income (accident and sickness) applied for but not approved, applying for Disability income (accident only)?

Yes No

Accidental death:

\$ _____

Children's term:

\$ _____

Critical illness (accelerated death benefit):

\$ _____

Waiver of premium

Other rider(s): _____

Remarks:

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.

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

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:

\$ _____

Source of lump sum premium: _____

Riders (Subject to state and product availability.)

Accidental death:

\$ _____

Children's term:

\$ _____

Disability income (accident only):

\$ _____

Waiver of monthly deductions

Guaranteed purchase option

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. 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.

The Independent Order of Foresters ("Foresters")

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

Proposed Insured

First name: _____ Middle name: _____ Last name: _____

Advantage Plus 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" 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 provisions will automatically apply, if premium is overdue at the end of the Grace Period, resulting in either reduced coverage or surrender.

Riders (Subject to state and product availability.)

Accidental death: \$ _____ Children's term: \$ _____ Disability income (accident only): \$ _____

Guaranteed insurability Term: 10 year 20 year \$ _____ Waiver of premium

<p><input type="radio"/> Flexible payment paid-up additions Maximum annual payment amount: \$ _____ Planned payment amount (by mode): \$ _____ (must be the same mode as premiums for certificate)</p> <p>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.</p>	<p><input type="radio"/> Single payment paid-up additions Planned payment amount: \$ _____</p> <p>Payment method: <input type="radio"/> Check <input type="radio"/> PAC (planned payment amount will be added to the amount to be drafted as first premium payment).</p> <p><input type="radio"/> Transfer <input type="radio"/> Other _____</p> <p>Source of payment: _____</p>
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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. 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.

The Independent Order of Foresters ("Foresters")

Application for Individual Life Insurance

Proposed Insured				
First name:	Middle name:	Last name:	<input type="radio"/> Male <input type="radio"/> Female	
Street address (cannot be a P.O. Box.):		City:	State:	Zip:
Home phone #:	Alternate phone # / Cell #:	Best time to call:	Date of birth (mmm/dd/yyyy):	State & Country of birth:
Social security #:	U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____			Primary language: <input type="radio"/> English <input type="radio"/> Spanish
Type of Photo I.D. (used to verify identity): <input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government ID: _____ Photo I.D. # _____				
Occupation & duties:			<input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Seasonal	
Hours worked per week (past 6 months): _____		Income (past 12 months): \$ _____		
Number of weeks worked in the past 12 months: _____		Net worth: \$ _____		
Foresters member? <input type="radio"/> Yes <input type="radio"/> No, applying for membership.		Email address (optional): _____		

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.)

Primary Beneficiary(ies)			
Name, date of birth, and address (street, city, state, zip code) of each primary beneficiary.	Relationship to proposed insured.	% Share	
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		Total	
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		must equal	
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		100%	
Contingent Beneficiary(ies)			
Name, date of birth, and address (street, city, state, zip code) of each contingent beneficiary.	Relationship to proposed insured.	% Share	
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		Total must	
Name: _____ Date of birth (mmm/dd/yyyy): _____ Address: _____		equal 100%	

Owner (Complete only if other than the proposed insured. If not completed the proposed insured is the owner. If a contingent owner is to be named, use Contingent Owner/Other Payer Identification Form.)

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust:		Social security # / Tax I.D. #:	
Street address (cannot be a P.O. Box.):	City:	State:	Zip:
Relationship to the proposed insured:		Email address (optional):	
Phone #:	If Trust, name of Trustee:	If Trust, date of Trust agreement:	
If Individual:			
<input type="radio"/> Male	Date of birth (mmm/dd/yyyy):	U.S. citizen?	
<input type="radio"/> Female		<input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____	

Other Insurance

1. Is there another annuity or life insurance application pending for the proposed insured with Foresters or another insurer? Yes No

2. Does the proposed insured 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 1 or 2, complete the chart below. Also include information about Foresters life insurance or annuity certificate(s).

Name of Insurer	Annuity/Life insurance \$	Accidental death \$	Critical illness \$	Disability income (per month) \$	Issue year or indicate if pending

3. Has the proposed insured ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date _____ and reason _____ Yes No

4. 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

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. Check the State requirements as these would need to be satisfied before the certificate can be issued. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those completed within the past 13 months.

Children's Questions (Complete only if applying for Children's Term Coverage. For purposes of these questions, "diagnosed", "advised" and "treatment" mean by a licensed physician or medical practitioner.)

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

5. Has a child listed above:

a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease? Yes No

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

If "Yes", to either question 5a or 5b, complete the chart below.

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

Financial Questions

<p>6. Is there an intention, or an arrangement, that all or part of the insurance applied for will be:</p> <p>a) Paid for by borrowing, financing or receiving money or any other property? <input type="radio"/> Yes <input type="radio"/> No</p> <p>b) Transferred, assigned, sold or pledged? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If "Yes", to either question 6a or 6b provide details. _____</p> <p>_____</p> <p>_____</p>	
<p>7. Has the proposed insured, owner or a beneficiary arranged, been offered, or received, an inducement, fee or compensation to buy, or pay for, the insurance applied for? If "Yes", provide details. _____</p> <p>_____</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>

For each "Yes" answer in the Lifestyle and Medical Questions sections additional information may be required. Completing the corresponding questionnaire or, if no corresponding questionnaire is available, providing details in the Additional Information section may help speed up the Underwriting process.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the proposed insured.)

<p>8. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify:</p> <p>Type used: _____ Date last used: _____</p> <p>If currently smoking, how many pack(s) per day? _____</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>9. Do you currently drink alcohol? If "Yes", specify:</p> <p>How many times per week? _____ How many drinks per occasion? _____</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>10. Within the past 10 years have you:</p> <p>a) Used marijuana, heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or a controlled substance except as prescribed by a licensed physician or medical practitioner? <input type="radio"/> Yes <input type="radio"/> No</p> <p>b) Received or been advised to receive treatment or counseling, by a licensed physician or medical practitioner, to discontinue or reduce the use of alcohol, non-prescribed or prescribed drugs? <input type="radio"/> Yes <input type="radio"/> No</p>	
<p>11. Do you expect to travel outside of North America or change your country of residence within the next 2 years? If "Yes", indicate each that applies and provide the details requested:</p> <p><input type="radio"/> Travel outside of North America: Country(ies): _____ Duration of travel (in weeks): _____</p> <p><input type="radio"/> Change country of residence: Country: _____</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>12. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>13. Have you, within the past 2 years, flown, or do you in the future intend to fly, in an aircraft as a student pilot, licensed pilot or crew member?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>14. Have you, within the past 2 years, engaged, or do you in the future intend to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>15. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____</p> <p>_____</p> <p>_____</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>16. Within the past 10 years have you:</p> <p>a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify:</p> <p>Number of convictions: _____ State where each conviction occurred: _____</p> <p>Date of most recent conviction: _____</p> <p style="text-align: center;">(mmm/dd/yyyy)</p> <p>b) Been convicted of, pled guilty to, or are you currently on probation or incarcerated for, a felony? If "Yes", provide date(s) and reason(s). _____</p> <p>_____</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>

Medical Questions (For purposes of these questions “you” and “your” mean the proposed insured, “diagnosed”, “advised”, “tested” and “treatment” mean by a licensed physician or medical practitioner. For each “Yes” answer, provide details in the Additional Information section.)

17. a) Your: Height: _____ Weight: _____
 b) Have you had a weight change of 10 pounds or more, within the past 12 months? If “Yes”, specify:
 Gain Loss How many pounds? _____
 Reason: Diet/Better eating Exercise Childbirth Other

Yes No

18. Date you last consulted a physician: _____
 Physician Name: _____
 Address: _____
 a) Reason(s): _____
 b) Were you advised that results of that consultation were within normal ranges? If “No”, provide details.

Yes No

19. Your Personal Physician(s), if different than question 18.
 Name: _____ Address: _____ Phone #: _____
 Name: _____ Address: _____ Phone #: _____

20. Within the past 5 years, have you consulted a physician other than identified in question 18 or 19, or a medical practitioner, or been a clinic, hospital or emergency room patient? Yes No

21. Are you presently taking prescription medication or under treatment? Yes No

22. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? Yes No

23. Do you have, alive or deceased, a parent or sibling diagnosed with or treated for, prior to age 65, diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington’s Chorea, Alzheimer’s, or other hereditary disorder? Yes No

Details to “Yes” answers to question 23.

	Age, if living	Age, at death	Details of condition / Cause of death
Father			
Mother			
Siblings			

24. Within the past 5 years, have you:
 a) Had or been advised to have a diagnostic test (other than for HIV) such as an EKG, CAT scan, MRI scan, echocardiogram, angiogram, biopsy, or endoscopy? Yes No
 b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known? Yes No
 c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled? 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 Identification Form)

First premium payment to be made by:

Pre-Authorized Check (PAC) Check (payable to Foresters) Other (complete Payment Form)

Subsequent premium payments to be made by:

Pre-Authorized Check (PAC) Direct Bill Other (complete Payment Form)

Payment mode:

Monthly (not available for direct bill) Quarterly Semi-annually Annually

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: _____

Street address: _____

City: _____ State: _____ Zip: _____

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, under the PAC selections made in the Payment Information and Authorization section (above), from that account or another account later identified or substituted by the payer. 2) The financial institution from which payments are to be drafted is authorized to treat each draft by Foresters as though it was made personally by the 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 according to the coverage(s) and certificate type issued. 4) This PAC plan 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 agreement 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

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 |

Temporary Life Insurance Agreement (TIA) Acknowledgement

Will the TIA be left with the owner?

- No. The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided or authorized.

X _____
(Owner's initials)

- Yes. Complete the TIA and leave it with the owner.

First premium payment, in the amount of \$ _____, is provided or authorized 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 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.

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.

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 insurance contract (defined as a certificate and each rider attached to that certificate) issued, if any, 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 honored by 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, or 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 may review, transfer and otherwise use, information provided in this Application to offer and issue (including post issue administration), other insurance products to me. 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) 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 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 every child named, if any, and proposed for insurance, in this Application. "Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business 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. 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 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: _____
(If the proposed insured is not a juvenile.)

Owner's signature: _____
(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: _____

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 personally met with the proposed insured, owner and each child and reviewed the document(s) used to verify identity and birth date; c) 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; d) This Application was reviewed by each person signing in the Signature Section before it was signed by that person; e) 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; f) 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; g) 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; h) 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.

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

Are you related to the proposed insured? Yes No

Producer's name (print full name): _____ Producer #: _____

Producer's signature: _____ Date: _____
(mmm/dd/yyyy)

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.

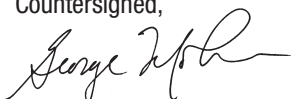
Termination of Temporary Coverage - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application 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 on the life of the proposed insured takes effect as described in that certificate, if a certificate is issued in response to the Application. 3) 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. 4) 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. 5) 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,



George Mohacsi, President & Chief Executive Officer

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

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 and agencies and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business 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.

Producer Report

Proposed Insured		
First name: _____ Middle name: _____ Last name: _____		
Producer's name	Producer #	% of split
Producer's name	Producer #	% of split
Producer's name	Producer #	% of split
1. Rating class applied for: _____ If underwriting approval is given other than as quoted, Foresters will contact you and, if we do not receive direction otherwise, the certificate will be issued to maintain face amount.		
2. Certificate date shall be: <input type="radio"/> Date issued <input type="radio"/> To save insurance age Certificate date can be backdated to save insurance age but is subject to rules and requires all back premiums to be collected.		
3. Are you related to the proposed insured? If "Yes", please state the relationship in the Producer Comments section below.		<input type="radio"/> Yes <input type="radio"/> No
4. Have you submitted an additional application to Foresters: a) On the proposed insured or owner (if other than the proposed insured)? b) 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.		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
5. Was a copy of the Buyer's Guide provided to the owner at the time of sale?		<input type="radio"/> Yes <input type="radio"/> No
6. If a personal health interview (PHI) was conducted as part of the application process, provide the PHI Inspection Reference ID #. _____		
7. Indicate in the chart below if age & amount requirements were ordered.		
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 in the Lifestyle and Medical Questions sections. 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