A–Z Life Coverage

Application for life insurance

Canada Protection Plan®

From Foresters Financial™

Application Checklist

To ensure priority service:

1 | Ensure that all applicable questions are completed before submitting. Print legibly in dark ink. Do not use "ditto" marks. Do not draw a line through any questions or answers. Do not make erasures or use liquid paper. If you cross out an error, each person signing the application must initial it.

2 | Attach an illustration for each insurance contract applied for.

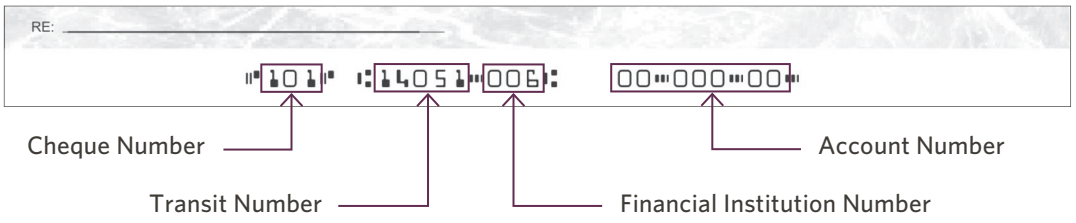
3 | Submit applicable disclosure forms if replacing existing life insurance.

4 | Note that the initial premium will be applied on the issue date of the insurance contract, which will be the date the insurance contract is actually issued.

5 | If premium payment is annual, ensure that the initial premium is paid with the application. COD applications are NOT allowed.

- If the initial premium is to be paid by cheque, include a current dated cheque payable to Foresters with the same date as the application.
- If the initial premium is to be paid by credit card, the frequency of premium payments must be annual.

6 | If premium payment is monthly by Pre-Authorized Debit (PAD), include a void cheque or complete the banking information on page 6 (see sample cheque below). For monthly (PAD) payment method, there is no premium debit for the first month.



7 | Please do not include credit card information on the application for life insurance.

8 | Each Advisor MUST have a valid licence and E&O on file with The Independent Order of Foresters or copies must be attached to this application.

9 | Notify your client that they may receive a verification call from the Insurer to verify the information on their application.

Plan Availability

1 Maximums shown are for combined coverage under all Plans of the same category.

2 Minimum is $50,000 for a Preferred term plan or rider or a Preferred Elite term rider, and $500,000 for a Preferred Elite term plan.

Base Plan	Issue Ages	Minimum	Maximum
Guaranteed Acceptance Life	18 — 60	$10,000	$50,000
	61 — 75	$5,000	$50,000
Deferred Life	18 — 60	$10,000	$75,000
	61 — 80	$5,000	$50,000
Deferred Elite Life	18 — 60	$10,000	$350,000 [1]
	61 — 80	$5,000	$350,000 [1]
Simplified Elite Life	18 — 60	$10,000	$500,000 [1]
	61 — 80	$5,000	$350,000 [1]
Preferred Life	18 — 80	$50,000	$1,000,000 [1]
Preferred Elite Life	18 — 80	$500,000	$1,000,000 [1]
Base Plan or Rider (available as Deferred Elite, Simplified Elite, Preferred and Preferred Elite)			
10 Year Term	18 — 70	$25,000 [2]	Maximum depends on age and plan — see above
20 Year Term	18 — 60	$25,000 [2]	
25 Year Term	18 — 55	$25,000 [2]	
25 Year Decreasing Term	18 — 60	$25,000 [2]	
Rider Only			
Accidental Death Benefit	18 — 65	Lesser of one times coverage and $10,000	Lesser of five times coverage and $250,000
Child Term Benefit	18 — 60 (parent)	$5,000, $10,000 or $15,000	
Hospital Cash Benefit	18 — 65	$25/day, $50/day or $100/day	

INSURED

In this application, Insured means the person proposed to be the insured.

1 Must be a Canadian Citizen, Permanent Resident or with a valid work or study permit to apply.

The maximum amount for an Insured on a work or study permit is $250,000.

2 For permanent life insurance, when the Insured is the Owner, if SIN is not provided here, we may ask for it in future, including on surrender of the insurance contract.

3 Physician's information is required for all products other than Guaranteed Acceptance Life.

Name ..... (First / Middle / Last)

Sex at birth: ○ Male ○ Female

Date of Birth ..... (MM / DD / YY)

Country of Birth .....

○ Canadian Citizen [1]
○ Permanent Resident [1]
○ Work Permit/Study Permit [1]

Telephone
Primary .....
Work / Other .....

Address ..... (Street Name & Number / Apartment Number)

..... (City / Town / Province / Territory / Postal Code)

Best date and time to call for verification, if applicable (be specific):
..... (Date / Time)

Social Insurance Number [2] .....

Email (Optional) .....

Occupation .....

Driver's Licence (or Gov't Issued Photo ID # and Type)
..... (Number (and type) / Province / Territory of Issue / Expiry Date (MM/DD/YY))

Are you a Foresters member?
○ Yes ○ No, applying for membership

Your physician's name [3] .....

Your physician's address [3] .....

OWNER

Complete Owner details only if different than Insured

4 If the Owner is a Corporation/Entity:
- the signature must be accompanied by either the company name and title of the signing officer OR a company seal
- complete the Identity Verification Corporations and Other Entities (IVCOE) form 105994 CAN and provide a document that verifies the existence of the entity e.g. articles of incorporation.

5 For permanent life insurance, if SIN is not provided here, we may ask for it in future, including on surrender of the insurance contract.

Full Legal Name, or Corporation/Entity [4] .....

Date of Birth .....

Owner is: ○ Insured
○ Other — *complete this section*

Address ..... (Street Name & Number / Apartment Number)

..... (City / Town / Province / Territory / Postal Code)

Telephone ..... Primary
..... Work / Other

Relationship to Insured .....

Principal Business or Occupation .....

Social Insurance Number [5] .....

Driver's Licence (or Gov't Issued Photo ID # and Type)
..... (Number (and type) / Province/Territory of Issue / Expiry Date (MM/DD/YY))

Email (Optional) .....

CONTINGENT OWNER

Full Legal Name, or Corporation/Entity ..... Relationship to Owner .....

BENEFICIARY

Total % share must equal 100% for Primary and 100% for Contingent Beneficiaries.

! Important: Each beneficiary is revocable unless indicated otherwise. However in Quebec, the designation of a legally married spouse of the Owner is irrevocable unless expressly indicated to be revocable.

Beneficiary Name	Relationship to Insured (or to Owner in Quebec)	Date of Birth MM/DD/YY	%Share	Revocable (R) Irrevocable (I)	Primary (P) Contingent (C)
				○ R ○ I	○ P ○ C
				○ R ○ I	○ P ○ C
				○ R ○ I	○ P ○ C

If a beneficiary is a minor: In all provinces except Quebec, a trustee should be named to receive funds on the minor's behalf.

Trustee Name ..... Relationship to Owner .....

In Quebec, the proceeds payable to a minor will be paid to the parent(s) (or legal guardian, if applicable).

PAYOR

Complete Payor details only if different than Insured or Owner.

Payor is: ○ Insured ○ Owner ○ Other — *complete this section* Relationship to Insured .....

Full Name ..... Date of Birth ..... (MM / DD / YY)

Address ..... (Street Name & Number / Apartment Number / City / Town / Province/Territory / Postal Code)

02 Owner's International Tax Status

Complete only if applying for permanent life insurance.

Are you a U.S. Resident for tax purposes, or a U.S. citizen, and/or a resident of another country for tax purposes? ○ Yes ○ No

If YES, provide ..... U.S. Tax Identification Number *and/or* ..... Name of Country(ies) *and* ..... Tax Identification Number(s)

03 Eligibility Questions

For all Eligibility Questions, "You" and "Your" refer to the Insured.

Complete these questions for all applications. Then continue to the next section.

1 | Within the last 12 months have you, a. used tobacco or nicotine in any form (excluding 12 cigars or less) or b. vaped or used an electronic cigarette in any form or c. used, more than 6 times per week, marijuana in any form (excluding CBD oil or edibles)?
If YES, smoker rates apply. ..... ○ Yes ○ No

2 | Will premiums be stopped, or coverage be reduced or discontinued, on existing life insurance coverage or an annuity if the insurance applied for in this application is issued?
If YES, state insurer, amount and plan, and complete the Comparison Disclosure Statement or Life Insurance Replacement Declaration required in your province.
..... ○ Yes ○ No

Insurer ..... **Amount** ..... **Plan** .....

A NO MEDICAL REQUIRED

YES If a question is answered YES in this section, apply for

Guaranteed Acceptance Life
Maximum $50,000

NO If ALL NO answers are provided, continue to section **B**

Height and Weight Table
(Section A, Question 7)

Height	Weight
4'8" — 4'10" 142 cm — 147 cm	230 lbs 104 kg
4'11" — 5'1" 148 cm — 155 cm	247 lbs 112 kg
5'2" — 5'4" 156 cm — 163 cm	273 lbs 124 kg
5'5" — 5'7" 164 cm — 170 cm	300 lbs 136 kg
5'8" — 5'10" 171 cm — 178 cm	328 lbs 149 kg
5'11" — 6'1" 179 cm — 185 cm	358 lbs 162 kg
6'2" — 6'4" 186 cm — 193 cm	389 lbs 176 kg
6'5" — 6'7" 194 cm — 201 cm	420 lbs 191 kg

1 | Do you require assistance with 2 or more of the activities of daily living, such as, but not limited to, getting up, walking, bathing, showering, washing, toileting, taking medication, dressing or feeding? ..... ○ Yes ○ No

2 | Are you a resident of a long-term care facility, nursing home, nursing facility or assisted living residence? ..... ○ Yes ○ No

3 | Are you bedridden or wheelchair bound, regardless of your place of residence? ..... ○ Yes ○ No

4 | Have you ever been advised to receive, or are you on a waiting list for, or are you the recipient of, an organ or bone marrow transplant (excluding corneal transplant)? ..... ○ Yes ○ No

5 | Within the last 60 days, have you been admitted to a hospital for more than 48 consecutive hours (excluding pregnancy)? ..... ○ Yes ○ No

6 | a. Have you ever been advised to have surgery or a procedure, or an investigation or diagnostic test of any type (excluding annual tests with normal results), or to consult with a medical professional or facility, that has not yet started or been completed or the result of which is not yet known, or ..... ○ Yes ○ No
b. have you ever not followed treatment or not taken medication advised or prescribed by a medical professional, or ..... ○ Yes ○ No
c. within the last 60 days have you had or been advised of an abnormal test result that changed existing treatment or resulted in new treatment for an ongoing condition? ..... ○ Yes ○ No

7 | Referring to the Height and Weight table for this question, is your weight greater than that indicated for your height? ..... ○ Yes ○ No

8 | Have you ever tested positive for Human Immunodeficiency Virus (HIV) or had or been told you have, or been treated for, Acquired Immunodeficiency Syndrome (AIDS), Aids Related Complex (ARC), or a disease or disorder of the immune system excluding lupus, rheumatoid arthritis or type 1 diabetes? ..... ○ Yes ○ No

9 | Have you ever had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for:
a. metastatic cancer, a recurrence of cancer, or a second diagnosis of cancer (excluding basal cell carcinoma) or ..... ○ Yes ○ No
b. a chronic lung or respiratory condition (excluding sleep apnea), such as, but not limited to, Chronic Obstructive Pulmonary Disease (COPD), emphysema, or pulmonary fibrosis, which requires or required the periodic use of oxygen, or the use of a steroid (excluding steroid treatment for asthma) or ..... ○ Yes ○ No
c. dementia, Alzheimer's, memory loss, Muscular Dystrophy, myotonic dystrophy, Parkinson's disease, Huntington's Chorea or Amyotrophic Lateral Sclerosis (ALS) or ..... ○ Yes ○ No
d. congestive heart failure, systolic or diastolic heart failure or cardiomyopathy? ..... ○ Yes ○ No

10 | Prior to age 40, have you had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for cardiac chest pain (angina), heart attack (myocardial infarction), coronary artery disease, atherosclerosis, stroke (CVA), transient ischemic attack (TIA), chronic kidney disease, an aneurysm anywhere in your body or had heart bypass surgery, angioplasty or stent insertion? ..... ○ Yes ○ No

11 | Within the last 12 months, have you:
- a. used (except as prescribed by a medical professional) a narcotic or barbiturate or ... ○ Yes ○ No
- b. used (whether prescribed by a medical professional or not) heroin, a psychoactive drug, cocaine, crack, methadone, fentanyl or another similar agent or ... ○ Yes ○ No
- c. been in a hospital or facility for drug or alcohol treatment? ... ○ Yes ○ No

12 | Within the last 24 months, have you been convicted, incarcerated, on probation or parole, or is a charge pending or are you awaiting sentencing, for a criminal offence? ... ○ Yes ○ No

13 | Have you ever been diagnosed with a life threatening, critical, or terminal condition for which a medical professional has estimated that you have a reduced life expectancy? ... ○ Yes ○ No

B NO MEDICAL REQUIRED

YES If a question is answered YES in this section, apply for

Deferred Life
Maximum $75,000

NO If ALL NO answers are provided, continue to section **C**

1 | Within the last 2 years, have you had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication, or had surgery or a procedure for:
- a. cardiac chest pain (angina), heart attack (myocardial infarction), cardiac disease, valvular disease or disorder, heart rhythm disorder, coronary artery disease, atherosclerosis or disorder of a blood vessel, an aneurysm anywhere in your body, stroke (CVA) or transient ischemic attack (TIA) or a pacemaker or defibrillator, or had heart bypass surgery, angioplasty, stent insertion or valve surgery or ... ○ Yes ○ No
- b. circulatory problems in the legs and/or feet (peripheral vascular, arterial and/or neuropathy)? ... ○ Yes ○ No

2 | Within the last 12 months, have you had or been told you have, or been investigated (with a positive or unknown result) or treated for, cancer (of any type excluding basal cell carcinoma), an abnormal growth or a malignant tumour? ... ○ Yes ○ No

3 | Have you ever had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for:
- a. chronic kidney disease such as, but not limited to, diabetic nephropathy, polycystic kidney disease (PKD), chronic renal failure at any stage, or been advised to be investigated for PKD or ... ○ Yes ○ No
- b. have a parental family history of PKD and you have not yet been investigated for PKD or ... ○ Yes ○ No
- c. liver disease such as, but not limited to, cirrhosis or hepatitis (excluding hepatitis A and B) or ... ○ Yes ○ No
- d. chronic or hereditary pancreatitis? ... ○ Yes ○ No

4 | Within the last 12 months, have you been in a hospital or other facility for more than 24 consecutive hours for a mental health condition such as, but not limited to, depression, anxiety or psychosis? ... ○ Yes ○ No

5 | Are you age 29 or under and have you ever had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for diabetes or your blood sugar level (excluding gestational diabetes)? ... ○ Yes ○ No

6 | Have you ever had or been told you have, or been investigated (with a positive or unknown result), or treated, or taken medication, or advised to take or prescribed medication for diabetes and any of the following: coronary artery disease, cardiac chest pain (angina), heart attack (myocardial infarction), stroke (CVA), tingling or burning or loss of sensation in an extremity (neuropathy), peripheral vascular or arterial disease, loss of vision (retinopathy), kidney disease (nephropathy), or had heart bypass surgery, angioplasty, stent insertion or amputation? ... ○ Yes ○ No

7 | Do you have a congenital development disorder such as, but not limited to, Down's Syndrome or Autism? ... ○ Yes ○ No

C NO MEDICAL REQUIRED

YES If a question is answered YES in this section, apply for

Deferred Elite Plans
Maximum $350,000

NO If ALL NO answers are provided, continue to section **D**

1 | Have you ever had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for bipolar disorder, schizophrenia, manic-depression or psychosis? ... ○ Yes ○ No

2 | Within the last 5 years, have you been treated or received medical advice or counseling for, or been advised to seek treatment for, or to cease or reduce, the use of alcohol or drugs? ... ○ Yes ○ No

3 | Within the last 5 years, have you:
- a. used (except as prescribed by a medical professional) a narcotic or barbiturate or ... ○ Yes ○ No
- b. used (whether prescribed by a medical professional or not) heroin, psychoactive drug, cocaine, crack, methadone, fentanyl or another similar agent or ... ○ Yes ○ No
- c. been in a hospital or facility for drug or alcohol treatment? ... ○ Yes ○ No

4 | Within the last 5 years, have you had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for a chronic lung or respiratory condition (excluding asthma) such as, but not limited to, chronic obstructive pulmonary disease (COPD), emphysema or pulmonary fibrosis? ... ○ Yes ○ No

5 | Within the last 5 years, have you been convicted, incarcerated, on probation or parole, or are you awaiting sentencing, for a criminal offence? ... ○ Yes ○ No

Height and Weight Table
(Section C, Question 14)

Height	Weight
4'8" — 4'10" 142 cm — 147 cm	79 — 185 lbs 36 — 84 kg
4'11" — 5'1" 148 cm — 155 cm	87 — 199 lbs 39 — 90 kg
5'2" — 5'4" 156 cm — 163 cm	94 — 215 lbs 43 — 98 kg
5'5" — 5'7" 164 cm — 170 cm	104 — 235 lbs 47 — 107 kg
5'8" — 5'10" 171 cm — 178 cm	115 — 260 lbs 52 — 118 kg
5'11" — 6'1" 179 cm — 185 cm	125 — 282 lbs 57 — 128 kg
6'2" — 6'4" 186 cm — 193 cm	139 — 305 lbs 63 — 138 kg
6'5" — 6'7" 194 cm — 201 cm	149 — 333 lbs 68 — 151 kg

6 | After the age of 40, have you had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication for a neurological condition such as, but not limited to, a. epilepsy or b. multiple sclerosis or c. seizures with loss of consciousness? ○ Yes ○ No

7 | Within the last 4 years, have you had or been told you have, or been investigated (with a positive or unknown result) or treated, or taken medication, or been advised to take or prescribed medication, or had surgery or a procedure for:
a. cardiac chest pain (angina), heart attack (myocardial infarction), cardiac disease, valvular disease or disorder, heart rhythm disorder, coronary artery disease, atherosclerosis or disorder of a blood vessel, an aneurysm anywhere in your body, stroke (CVA) or transient ischemic attack (TIA) or a pacemaker or defibrillator, or had heart bypass surgery, angioplasty, stent insertion or valve surgery or ○ Yes ○ No
b. circulatory problems in the legs and/or feet (peripheral vascular, arterial and/or neuropathy)? ○ Yes ○ No

8 | Do you have diabetes that was diagnosed at age 39 or under and within the last 12 months have you taken insulin or been advised to take or prescribed insulin or medication for diabetes? ○ Yes ○ No

9 | Do you have diabetes and within the last 6 months:
a. has insulin been advised or prescribed as a new treatment or ○ Yes ○ No
b. has the prescribed dosage of insulin been increased or ○ Yes ○ No
c. has another form of insulin been added to the treatment plan? ○ Yes ○ No

10 | Do you plan to travel outside North America, the Caribbean, Australia, the United Kingdom, New Zealand or the European Union countries for more than 12 consecutive weeks in the next 12 months? ○ Yes ○ No

11 | Within the last 12 months, have you had a weight loss of 10% or more of your body weight, other than due to intentional dieting? ○ Yes ○ No

12 | Within the last 12 months, have you had unexplained blood in your urine or stool? ○ Yes ○ No

13 | Within the last 10 years, have you had or been told you have, or been investigated (with a positive or unknown result) or treated for, cancer (of any type excluding basal cell carcinoma), an abnormal growth or a malignant tumour? ○ Yes ○ No

14 | Referring to the Height and Weight table for this question, is your weight outside the range indicated for your height? (For females, deduct 5 lbs. or 3 kg from the lower range for the given height) ○ Yes ○ No

D NO MEDICAL REQUIRED

YES If a question is answered YES in this section, apply for

Simplified Elite Plans
Maximum $500,000

NO If ALL NO answers are provided, **continue to section E ONLY if you wish to apply for**

Preferred Plans*
Preferred Elite Plans*

* You may qualify for one of these plans subject to underwriting requirements and approvals.

1 | Within the last 12 months, have you had or been told you have, or been investigated (with a positive or unknown result) or treated for, multiple sclerosis? ○ Yes ○ No

2 | Have you ever had or been told you have, or been investigated (with a positive or unknown result) or treated for, cancer (of any type, excluding basal cell carcinoma), an abnormal growth or a malignant tumour? ○ Yes ○ No

3 | Have you ever had or been told you have, or been investigated (with a positive or unknown result) or treated for, diabetes (excluding gestational diabetes) or within the last 6 months had an A1C greater than 8.5? ○ Yes ○ No

4 | Within the last 12 months, has there been a change in your medication (increased or decreased), or have you been advised to take or prescribed a new medication for an ongoing condition? ○ Yes ○ No

5 | Within the last 10 years, have you been convicted, incarcerated, on probation or parole, or are you awaiting sentencing for, a criminal offense, or within the last 2 years have you been charged with driving under the influence or impaired driving? ○ Yes ○ No

6 | Within the last 2 years, have you been involved in, or do you plan to do so within the next year, the operation of an aircraft as a pilot or student pilot (scheduled commercial pilots excluded), or a hazardous sport such as, but not limited to, scuba diving, motor vehicle racing, mountain climbing, back country skiing or sky diving? ○ Yes ○ No

7 | Within the last 2 years, has your driver's license been suspended or revoked, or within the last 12 months have you had more than 3 moving violations? ○ Yes ○ No

8 | Have 2 or more members of your immediate family (father, mother, brothers, sisters) ever had, or been treated for, or diagnosed with, cancer, heart disease, stroke (CVA) or transient ischemic attack (TIA), or has any member of your immediate family, before the age of 60, been treated for or diagnosed with polycystic kidney disease, Huntington's Chorea, or a hereditary disease or disorder? ○ Yes ○ No

E

MAY BE SUBJECT TO UNDERWRITING

Preferred Plans

Minimum $50,000
Maximum $1,000,000

The plan you may be eligible for will be determined by our underwriting department.

1 | Have you ever been prescribed a medication that was for more than 30 days for a medical condition? ○ Yes ○ No

If YES, please advise the name of the prescription(s) and the nature of the medical condition they were prescribed for.

Details

2 | Date you last consulted a physician .....

Reason for consult .....

F

SUBJECT TO UNDERWRITING

Preferred Elite Plans

Minimum $500,000
Maximum $1,000,000

The plan you may be eligible for will be determined by our underwriting department.

1 | What is your current height and weight?

Imperial ..... ft'in" / ..... lbs Metric ..... cm / ..... kg

2 | Within the past 24 months, have you used by any means (including electronic vaporizer or "vaping"), a substance or product containing tobacco, nicotine or marijuana? *If YES, smoker rates applicable.* ○ Yes ○ No

04 Coverage Details

1 Maximum two term insurance riders
- >> Riders can only be added if base is longer than rider term period (not equal).
- >> Term insurance riders are not available with Guaranteed Acceptance Life, Deferred Life or any 20 Pay plans.

2 Complete Child Term Benefit questions on page 5

Not available with:
- >> Guaranteed Acceptance Life
- >> Deferred Life

3 Not available with:
- >> Guaranteed Acceptance Life
- >> Deferred Life
- >> Deferred Elite Life
- >> Deferred Elite Term

Permanent Insurance Plan	Premium Payment Period	Amount of Insurance
○ Guaranteed Acceptance Life *(Ages 18–75)* ○ Deferred Life *(Ages 18–80)* ○ Deferred Elite Life *(Ages 18–80)* ○ Simplified Elite Life *(Ages 18–80)* ○ Preferred Life *(Ages 18–80)* ○ Preferred Elite Life *(Ages 18–80)*	○ Pay to Age 100 ○ 20 Pay *Not available for:* >> Guaranteed Acceptance Life >> Deferred Life	$ .....

Term Insurance Plan	Term Period	Amount of Insurance
○ Deferred Elite Term ○ Simplified Elite Term ○ Preferred Term ○ Preferred Elite Term	○ 10 Year *(Ages 18–70)* ○ 20 Year *(Ages 18–60)* ○ 25 Year *(Ages 18–55)* ○ 25 Year Decreasing *(Ages 18–60)*	$ .....

Optional Riders	Amount
☐ 10 Year Term [1] *(Ages 18–70)*	$ .....
☐ 20 Year Term [1] *(Ages 18–60)*	$ .....
☐ 25 Year Term [1] *(Ages 18–55)*	$ .....
☐ 25 Year Decreasing Term [1] *(Ages 18–60)*	$ .....
☐ Accidental Death Benefit *(Ages 18–65)*	$ .....
☐ Child Term Benefit [2] *(Ages 18–60)*	○ $5,000 ○ $10,000 ○ $15,000
☐ Hospital Cash Benefit [3] *(Ages 18–65)*	○ $25/day ○ $50/day ○ $100/day

05 Child Term Benefit

ELIGIBILITY QUESTIONS

Identify each child of the Insured under 18 years of age.

Child Name	Date of Birth (MM/DD/YY)	Age (Yrs)	Sex
			○ Male ○ Female
			○ Male ○ Female
			○ Male ○ Female
			○ Male ○ Female

1 | Has any child named above ever received medical care, surgical care, or prescribed medications or been investigated for or diagnosed with: cancer, leukemia, aplastic anemia, congenital or hereditary cardiac or neurological disease, bronchopulmonary dysplasia, cystic fibrosis, chronic kidney disease, Werdnig-Hoffmann disease (Infantile Spinal Muscular Atrophy), muscular dystrophy, chronic hepatitis, HIV positive, developmental problems, diabetes or autism? ○ Yes ○ No

2 | Has any child named above ever been referred by a physician for a specialist's consultation, been advised to have treatment or been advised to have a diagnostic test, any of which have not yet been completed? ○ Yes ○ No

If you answered YES to any of the questions for any child named above, please indicate the child's name below. The child named is excluded from the Child Term Benefit.

Child Name _____ Child Name _____ Child Name _____

06 Premium Details

PAYMENT PLAN

MONTHLY

For monthly (PAD) payment method, there is no premium debit for the first month.

ANNUAL

For annual payment method, unless the payor authorizes Foresters (the Insurer) to withdraw the initial premium by credit card, this application must be accompanied by a current dated cheque for the initial premium due, payable to Foresters. Annualized premium is less for annual payment method.

Premium payment frequency ○ Annual ○ Monthly (PAD)

Premium for the frequency $ _____

Premium payment method

- ○ **Cheque.** *Payable to Foresters; annual payment only.*
- ○ **Pre-Authorized Debit (PAD).** *Monthly payment only; complete PAD Plan Agreement on page 7.*
- ○ **Credit Card.** *Annual payment only. Foresters Financial will contact payors who intend to pay by credit card.*

Payment method for initial premium for annual payment, if different than payment method indicated above.
Initial premium for payment must be provided with this Application if annual payment method is chosen.

○ Cheque
○ Credit Card

07 Special Requests / Details

Any special requests, including premium and issue instructions, may be added here.

08 Third Party Determination

A third party is an individual or entity with an interest in a insurance contract, but is not the Insured, Owner or trustee for a minor beneficiary. Examples include power of attorney and executor.

Is a third party involved with this application for insurance, or will a third party pay the insurance premiums or have the use of, or access to, the cash value of any certificate applied for? ○ Yes ○ No

If YES, complete a separate Third Party Determination form 105815 CAN for each third party.

NOTE: Each premium for coverage applied for in this Application (if not paid with this Application), will be drawn from the account identified on the attached VOID cheque, or account information provided, unless otherwise instructed.

SAVINGS ACCOUNT

If a Savings account is used, please ensure it is eligible for pre-authorized payments.

SAMPLE CHEQUE

See the Application Checklist (on the inside cover page) for a sample cheque that shows location of transit #, financial institution # and account #.

Monthly Withdrawals under this PAD Agreement are: ○ Personal related ○ Business related

Withdrawal date requested (1st – 28th) .....

PAD bank account information to be taken from: ○ Attached VOID cheque ○ Banking information below *(complete if cheque is not attached)*

Type of Account ○ Chequing ○ Savings	Transit # *(5 digits)*	Account # .....
Financial Institution # *(3 digits)*	Name of Financial Institution	

Address of Financial Institution .....
Street Address City/Town Province/Territory Postal Code

PAD PLAN AGREEMENT

The payor, by signing below, verifies that the payor is an account holder of the account identified above or on the attached VOID cheque and agrees that:

1 | The Insurer is authorized to make deductions monthly under this Agreement from that account or another account later identified or substituted by the payor for premium and insurance charges for each insurance contract issued by that Insurer in response to this Application.

2 | The financial institution from which the deductions are to be made is authorized to treat each deduction by the Insurer as though the payor made it personally.

3 | The Insurer reserves the right to determine when the first deduction, if any, will be made and the amount of that deduction for each insurance contract issued by it; the subsequent deduction amounts may be variable.

4 | This Agreement is effective immediately and will continue until terminated, which either the payor or the Insurer may do at any time by providing notice of at least 30 days to the other. Payor may obtain a sample cancellation form or further information on the right to cancel a PAD Plan Agreement at his/her financial institution or by visiting www.payments.ca.

5 | Should funds not be available due to insufficient funds, the Insurer may, at its option, draw from the payor's account on the next scheduled withdrawal date for the insufficient amount applicable to each insurance contract while that insurance contract is in effect.

6 | The payor has certain recourse rights if any debit does not comply with this Agreement. For example, the payor has the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on recourse rights, the payor may contact his or her financial institution or visit www.payments.ca.

7 | If the payor is signing this Agreement electronically, the payor agrees that the time period for providing written confirmation of this Agreement, before the first deduction, can be reduced from 15 days to 3 days. If handwriting the signature, written confirmation is not required before the first deduction which can be made at any time.

8 | The payor may contact the Insurer at its address and phone number:

Attention: Certificate Owner Services, Foresters, 789 Don Mills Road, Toronto, ON, Canada M3C 1T9
Phone Number: 1-877-629-9090

The payor waives the right to receive pre-notification of the amount and date of the first deduction and of a change in the deduction amount required as premium or charges for each insurance contract in effect, or a change in amount requested by the payor by whatever means.

The account holder must sign this PAD Plan Agreement as his/her name appears on bank records for the account provided.

The payor authorizes disclosure of payor and account information for identity verification and record keeping purposes and to administer payments, the insurance contract and benefits.

Signature of Account Holder ..... Date .....
MM / DD / YY

Signature of Joint Account Holder *(if applicable)* ..... Date .....
MM / DD / YY

DEFINITIONS

These definitions apply for purposes of this Agreement and Authorization.

"Application" means this A-Z Life Coverage Application for Life Insurance. "Insured" and "Owner" mean each person identified as such in this Application. "I/me" means individually each person identified in this Application as either the Insured or the Owner. "Insurer" means The Independent Order of Foresters. "Insurance Contract" means an insurance contract issued by the Insurer in response to this Application and includes each rider that is attached to it. "Authorized Purpose" means: assessing, servicing or administering insurance coverage, an Insurance Contract, claim or the benefits of membership; identity verification, auditing, products and services; any other purpose as required or permitted by law. "Authorized Person" means the Insurer, reinsurer, advisor, insurance agency, managing general agency and market intermediary related to this Application or an Insurance Contract and the respective parent, subsidiaries, affiliates and authorized representatives of each and those performing services on behalf of one or more of the preceding in relation to an Authorized Purpose, this Application, or an Insurance Contract, benefit claim, membership or management of the respective business of each. "Child" means each child identified in the Child Term Benefit section of this Application.

AGREEMENT

I, by signing this Application, agree that:

1 | The statements and answers contained in this Application, documents and other evidence of insurability signed or provided by me, are true and complete and will be relied upon by the Insurer in deciding whether to issue an Insurance Contract.
2 | For the purpose of determining eligibility for insurance, the Insurer may consider risk characteristics other than those mentioned in the questions in this Application.
3 | An Insurance Contract issued, if any, by the Insurer will only come into effect according to the terms of that Insurance Contract, which may include factors such as the date this Application was approved, issue date of the Insurance Contract, payment of the first premium, and provided there is no change in insurability, as described in the Insurance Contract, prior to the date of delivery of the Insurance Contract.
4 | The Insurer may void the Insurance Contract in the event of any misrepresentation by me in this Application or in any other documents, information, evidence of insurability or answers delivered to the Insurer in connection with this Application.
5 | No advisor, medical examiner or any other person has authority to advise that any untrue or incomplete answer or information is acceptable and no person has the power, except for The Independent Order of Foresters President or Executive Secretary, or successor positions, to make, modify, or discharge a Insurance Contract.
6 | I expressly agree to have this Application, the Insurance Contract and any related documents in English. Je demande expressément que ce document ainsi que tous les documents y afférents soient rédigés en anglais.
7 | The Insured has received a copy of the Important Notices page.
8 | Changes or corrections made to this Application, if any, by the Insurer are ratified by the Owner if the Insurance Contract delivered to the Owner is not returned to the Insurer during the right to examine period.
9 | If I have chosen to provide a current internet email address or other electronic contact information in this Application or choose to provide such address or contact information in the future, the Insurer and its parent, subsidiaries and affiliates may use that address or contact information to send messages, information or documents to me electronically relating, directly or indirectly, to them, this Application, the Insurance Contract, or to membership, events, benefits, claims, administration or other goods and services.
10 | An Insurance Contract issued, if any, in response to this application, the Insurer's Instruments of Incorporation, Constitution and the respective amendments.

AUTHORIZATION

A photocopy of this authorization shall be as valid as the original.

I, by signing this Application, authorize, on my own behalf and on behalf of each Child, the collection and use of information about us, by an Authorized Person for an Authorized Purpose, from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan, other insurer or institution; public records; or MIB, LLC.

I, by signing this Application, authorize, on my own behalf and on behalf of each Child, an Authorized Person to make a brief report about my and each Child's personal health information to MIB, LLC, even if this Application is cancelled or withdrawn. Information may be disclosed: between and among Authorized Persons; to companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law.

Each person providing this authorization may, by written notice to the Insurer, revoke their authorization. Revoking authorization, however, will not affect action(s) begun before receipt of notice or prevent an Authorized Person from using personal information to administer an Insurance Contract, or report to MIB, LLC if previously authorized to do so, or to inform of or administer the benefits of membership.

OTHER PRODUCTS AND SERVICES

I consent to receiving information by any method from the Insurer, its parent, subsidiaries and affiliates about other products and services. If you do not want to provide your consent for that purpose, check here ☐ or you may at any time withdraw your consent by writing to our Chief Privacy Officer at: Foresters, 789 Don Mills Rd., Toronto, ON M3C 1T9.

SIGNATURES

This Application must be current dated and received at the Foresters Financial Head Office within 14 days of signature date.

I understand and agree that my signature below applies to, and is for the purposes of, this entire Application.

Signature of Insured .....

Signature of Owner (only if different) .....

Signature of witness to all signatures .....

Dated at ..... (Province/Territory) this ..... day of ..... , 20 .....

Advisor's Name .....

Advisor's Report

ADVISOR INFORMATION

Advisor Name *(first, middle, last)*	Advisor Code	Agency Code	Split %

RELATIONSHIP TO INSURED AND DISCLOSURE

When shown original identification documents to verify identity, you must confirm that the documents are authentic, valid and current by reviewing both sides of each document.

1 | How long have you known the Insured? .....

2 | Are you related to the Insured? ◯ Yes ◯ No *If YES, what is the nature of your relationship?* .....

3 | Who initiated this application? ◯ Owner ◯ Insured ◯ Advisor ◯ Other *(specify)* .....

4 | Did you meet with the Owner and Insured in person to complete this application? ◯ Yes ◯ No

If NO, please indicate method for obtaining the answer to the questions in this application: ◯ Telephone and/or mail ◯ Video conference / Skype

5 | Did you verify the identity of the Owner, by confirming that the identification details provided in this application match original identification documents shown to you? ..... ◯ Yes ◯ No

6 | Was a needs analysis done? ..... ◯ Yes ◯ No

7 | Do you know of any information not disclosed in this application that may be important to assessing the insured's eligibility for the plan applied for? ..... ◯ Yes ◯ No

If YES, please provide details: .....

REQUIREMENTS ORDERED

Preferred Plans and Preferred Elite Plans ONLY

☐ Blood Chemistry Profile

☐ Paramedical Exam

Name of paramedical provider ..... Order Number .....

SIGNATURE OF ADVISOR WHO COMPLETED THIS APPLICATION AND ADVISOR'S REPORT

I provided to the Insured and the Owner the Important Notices page and a statement of disclosure outlining the companies I represent, the fact that I receive compensation for the sale of life and health insurance company products, and that I may receive additional compensation in the form of bonuses, conference programs or other incentives. I have also disclosed any conflicts or potential conflicts of interest with respect to this transaction.

To the best of my knowledge and belief, the information provided in the application is current, correct and complete. I am not aware of any additional information that is material to the underwriting and acceptance of this application that has not been disclosed in this application or Advisor's report.

Reasonable effort was exercised by me to determine if the Owner is acting on behalf of a third party. I confirmed the identification details as stated above on the date stated below. If I suspect that an undisclosed third party is involved, I will immediately email details to compliance@foresters.com.

Signature of Advisor ..... Date .....
MM / DD / YY

Signature of training supervisor where required ..... Date .....
MM / DD / YY

I have reviewed this application and Advisor's report.

Signature of servicing agent if different from above ..... Date .....
MM / DD / YY

Important Notices

(Detach and present to Insured)

Respecting your privacy is important to us at Foresters Financial. We will maintain your Personal Information in a confidential file to be used at our offices to provide you with our products and services and information about your Foresters membership. Information in your file will be collected, used and disclosed, on a continuing basis, by Foresters Financial, our employees, reinsurers, agents and representatives, service providers or professional consultants to determine your eligibility for our products and services; to assess or administer claims; to administer your insurance contract and address your questions; to tell you about, and provide, the benefits of membership; provide you with information about products, services or member benefits that may meet your needs; to help us continually improve our services and develop programs for our members; and as further described in the Authorization section of the application. We will restrict access to your file to our employees, service providers, representatives, affiliates and reinsurers who need the information in the performance of their duties for us and to any person or organization to whom you gave consent. Our employees, service providers, representatives, reinsurers and any of their service providers may be located outside Canada. As such, your Personal Information may be subject to the laws of other jurisdictions and may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in those countries. You are entitled to access your Personal Information contained in your file and, when applicable, to have it corrected. You may also ask us not to send you information about our products, services, or member benefits. To do either of these, please write to: Foresters Financial at 789 Don Mills Road, Toronto, ON, Canada M3C 1T9. To access our most recent privacy policies, please visit our websites at cpp.ca and foresters.com.

NOTICE REGARDING MIB

Information regarding your insurability will be treated as confidential. The Independent Order of Foresters or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. 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 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 or go to its website at www.mib.com to request disclosure online. 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 Park, Suite 400 Braintree, MA 02184-8734 or go to its website at Canadadisclosure@mib.com.

The Independent Order of Foresters or its reinsurers, may also release information in 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.

INSURANCE CONTRACT LIMITATIONS

In the case of suicide, within two years from the issue date of the insurance contract, the benefit is limited to a refund of premiums paid.

- **For Guaranteed Acceptance Life**, if death occurs within two years from the issued date of the insurance contract and is due to non-accidental causes(other than suicide), the death benefit will be equal to the premiums paid.
- **For Deferred Life**, if death occurs within two years from the issued date of the insurance contract and is due to non-accidental causes (other than suicide), the death benefit will be equal to the premiums paid plus 3% interest.
- **For Deferred Elite Life and Deferred Elite Term**, if death occurs within two years from the issued date of the insurance contract and is due to non-accidental causes (other than suicide), the death benefit will be equal, in the first year, to the premiums paid plus 3% interest and, in the second year, to 50% of the face amount.
- **For Accidental Death Benefit**, the benefit payable may be limited by factors such as the Insured's age and the cause of death. Please see your insurance contract for detailed terms and conditions.

The insurance contract that may be issued as a result of this application has important terms and limitations. You should review it carefully as soon as you receive it.

R E C E I P T

(Detach and present to Owner ONLY if a cheque was provided for payment of the first annual premium.)

The Independent Order of Foresters acknowledges the receipt of $ ..... to be applied in payment of the first premium for insurance on the life of .....

This payment meets the requirement to provide the first total premium before the Insurance contract is delivered to the Owner, if this payment is honoured when first presented to the financial institution from which it is to be collected, as one of the conditions to be met for coverage to come into effect as described in the Insurance contract.

If the Insurance contract is not received within six (6) weeks of the date of this receipt, please contact Foresters Financial at the address on the back cover.

Dated at ..... this ..... day of ....., 20.....
City / Province

The Owner has the right to cancel the Insurance contract issued and receive a full refund of premium paid for it by notifying the Insurer in writing and returning the Insurance contract within 10 days of first receiving it.

Thank you for placing your trust in Canada Protection Plan from Foresters Financial.

Along with reliable support and compassionate service, there are many other advantages to apply:

- ✓ Payments start in the second month - applicable on monthly payment plans only
- ✓ You can apply for coverage up to $500,000 on many no medical, simplified issue plans
- ✓ You can apply for coverage up to $1 million on all Preferred Plans
- ✓ If you are ages 18 to 80, you can apply
- ✓ Most of our term plans are renewable and convertible
- ✓ Low rates in comparison to similar plans and benefits

A-Z Life Coverage is underwritten by The Independent Order of Foresters, establish in 1874, which is a member of Assuris.

You may qualify to enjoy a valuable package of member benefits.[1]

From an online document preparation service[2] for creating customizable wills and powers of attorney to competitive scholarships and more.

Information about member benefits can be found on the foresters.com website. After the Insurance contract has been issued and delivered, you can register at my.foresters.com to access many of the member benefits.

[1] *Foresters member benefits are non-contractual, subject to benefit specific eligibility requirements, definitions and limitations and may be changed or cancelled without notice or are no longer available.*

[2] *LawAssure is provided by Epoq, Inc. Epoq is an independent service provider and is not affiliated with Foresters. Some features may not be available based on your jurisdiction. LawAssure is not available in the Yukon, the Northwest Territories and Nunavut. LawAssure is not a legal service or legal advice and is not a substitute for legal advice or services of a lawyer. Foresters Financial, its employees and life insurance representatives, do not provide, on Foresters behalf, legal, estate or tax advice.*

We stand by you today, so your loved ones are protected for tomorrow.

Canada Protection Plan®
From Foresters Financial™

Distributed by
Foresters Financial
789 Don Mills Road,
Toronto, ON, Canada
M3C 1T9

Tel: (416) 447-6060
Toll free: 877-447-6060
Fax: (416) 447-9881

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