Foresters Life Insurance Company
789 Don Mills Road, Toronto, ON, Canada M3C 1T9 T. 800 828 1540 foresters.com

Foresters Financial

Application for Live Well Critical Illness Insurance

1. Insured (In this Application, Insured refers to a person who is proposed for critical illness insurance)

First Name	Middle Name	Last Name	○ Male ○ Female
Date of Birth (mmm/dd/yyyy)	Country of Birth	Province/State of Birth	
Street Address			
City	Province	Postal Code	Foresters Member? ○ Yes ○ No, applying for membership
Primary Telephone	Alternate Telephone	Email Address*	

Current employment status (provide occupation information in Details):

○ Full time (30+ hours/week over the last 6 months)
○ Part time (less than 30 hours/week over the last 6 months)
○ Seasonal (30+ hours/week for less than 26 weeks during the last 12 months)
○ Business Owner (List nature of business in Details)
○ Not currently employed (provide occupation and reason in Details)

Details:

Status: ○ CDN citizen ○ Permanent Resident ○ Work Permit, (provide copy of your visa or work permit)

If Permanent Resident or Work Permit, how long have you lived in Canada? ○ Years ○ Months

2. Owner (An Owner must be at least 16 years old, or at least 18 in Quebec)

2.1 Owner is: ○ Insured ○ Other (Complete section 2.1)

Full Legal Name of Individual (First, Middle, Last) or Corporation/Entity			○ Male ○ Female
Address			Date of Birth (mmm/dd/yyyy)
City	Province		Postal Code
Primary Telephone	Alternate Telephone	Relationship to Insured	
Occupation	Email address*		
If Trust, Name of Trustee			If Trust, Date of Trust Agreement

2.2 Contingent Owner: (Optional)

Full Legal Name (First, Middle, Last) or Corporation/Entity	Date of Birth (mmm/dd/yyyy)	Relationship to Owner

*Please complete if you would like electronic delivery of your insurance contract and related documents and/or for the purposes described in the Agreements section of this Application.

3. Beneficiary

To designate a beneficiary for the Return of Premium on Death Benefit. The critical illness benefit payable is paid to the Owner.

3.1 Beneficiaries:

○ Primary ○ Contingent				
Name	Relationship [1]	Date of Birth	Share %[2]	○ Revocable[3] ○ Irrevocable[4]
○ Primary ○ Contingent				
Name	Relationship [1]	Date of Birth	Share %[2]	○ Revocable[3] ○ Irrevocable[4]
○ Primary ○ Contingent				
Name	Relationship [1]	Date of Birth	Share %[2]	○ Revocable[3] ○ Irrevocable[4]
○ Primary ○ Contingent				
Name	Relationship [1]	Date of Birth	Share %[2]	○ Revocable[3] ○ Irrevocable[4]
○ Primary ○ Contingent				
Name	Relationship [1]	Date of Birth	Share %[2]	○ Revocable[3] ○ Irrevocable[4]
○ Primary ○ Contingent				
Name	Relationship [1]	Date of Birth	Share %[2]	○ Revocable[3] ○ Irrevocable[4]

3.2 If Beneficiary is a Minor:

Name	Trustee	Relationship
Name (Minor 1)	Trustee Name[5]	Relationship to Owner
Name (Minor 2)	Trustee Name[5] ○ Same as Minor 1	Relationship to Owner
Name (Minor 3)	Trustee Name[5] ○ Same as Minor 1	Relationship to Owner

[1] List the beneficiary relationship to the Insured (except in Quebec). In Quebec, list the beneficiary relationship to the Owner

[2] Primary and Contingent Beneficiary Designations must total 100% respectively.

[3] Beneficiaries are revocable unless otherwise stated. However, in Quebec the designation of a legally married spouse of the Owner is irrevocable unless expressly stated to be revocable.

[4] If "irrevocable" is selected as the beneficiary type, certain transactions cannot be done without the consent of each irrevocable beneficiary. The changes, requiring that consent, include revoking that beneficiary or changing their share and may also include surrendering the insurance contract or changing the ownership.

[5] A trustee should be named to receive funds on the minor's behalf (except in Quebec). In Quebec, the proceeds payable to a minor will be paid to the parent(s)/legal guardian.

4. Coverage Information

Amount of Insurance $	○ Live Well T10 ○ Live Well T20 ○ Live Well T80	
Optional Riders	○ Return of Premium on Surrender or Expiry Rider	○ Disability Waiver of Premium Rider

5. Personal & Health Questions For purposes of these Section 5 questions, 'you' and 'your' mean the Insured.

5.1 Your eligibility

a) Have you ever had, been told you have, or been treated for Acquired Immunodeficiency Syndrome (AIDS) or have you ever tested positive for Human Immunodeficiency Virus (HIV)?	○ Yes ○ No
b) Do you have or ever had one or more of the * symptoms or complaints listed below for which you have not yet consulted with a medical professional or for which you are being investigated, or for which a diagnosis has not yet been made but you are under observation or have had a test recommended but not yet started or completed or for which the results are not yet known: *Chest pain, shortness of breath, radiating pain in the left arm, shoulder or back, pounding heart or change in heart rhythm, a lump, a persistent cough with no other symptom, blood in your urine or stool, a change in skin, moles or skin growth, an unexplained weight loss of 10 pounds or more without dieting or exercise, unexplained loss of appetite, chronic extreme fatigue without explanation.	○ Yes ○ No

If you answer "Yes" to either question in section 5.1, you do not qualify for a Live Well policy or a Live Well Plus policy.

5.2 Your lifestyle

a) Have you travelled or resided outside of Canada or the United States in the last 12 months or do you plan to travel or reside outside of Canada or the United States in the next 12 months?	○ Yes ○ No
b) Have you ever been charged with or convicted of a criminal offense, or is a criminal charge pending, or are you on parole, statutory release or probation?	○ Yes ○ No
c) In the last 10 years have you used any of the following: i. Illegal or illicit drug? ii. Controlled substance except as prescribed by a medical professional?	○ Yes ○ No
d) Have you ever been advised to reduce your consumption or frequency of use of alcohol or drugs or been treated for or been advised to be treated for alcohol or drug use? This includes joining or being advised to join an organization for alcohol or drug use.	○ Yes ○ No
e) In the last 3 years have you been convicted of or pled guilty to impaired, careless, reckless, negligent or distracted driving, or been charged with or convicted of driving under the influence or driving while impaired (includes refusing a breathalyzer test)?	○ Yes ○ No

5.3 Your health

a) Have you ever had cardiac surgery such as but not limited to heart bypass surgery, stent insertion, angioplasty, valve surgery or ablation?	○ Yes ○ No
b) Have you ever been treated for, had or been diagnosed with: i. diabetes type 1 or 2 or abnormal blood sugar? ii. a stroke (cerebrovascular accident), or TIA (transient ischemic attack), a disease or disorder of the blood vessels? iii. coronary artery disease, heart attack, congestive heart failure, cardiomyopathy, heart valve disease, congenital heart abnormality, atrial fibrillation, arrhythmia, or a disease or disorder of the heart? iv. an aneurysm?	○ Yes ○ No
c) Have you ever had an abnormal result from a cardiac, carotid or cerebrovascular test, without subsequent investigation establishing a normal test result, including but not limited to any of the following tests: EKG, stress test, echocardiogram, angiogram, cardiac catherization, carotid doppler, carotid angiogram, angiography, CT scan, MRI, arteriogram or electroencephalogram (EEG)?	○ Yes ○ No

	d) Have you ever been treated for, had or been diagnosed with: i. cancer, irregular shaped or changing moles or lesions, basal cell carcinoma, thyroid cancer, a benign or malignant brain tumor, cyst, polyp or any other growth or malignancy? ii. a blood, bleeding or clotting disorder, anemia, hemophilia, aplastic anemia or a disease or disorder related directly or indirectly to aplastic anemia? iii. breast lump or cyst, a disease or disorder of any of the prostate, ovary, uterus, kidney or bladder?	○ Yes ○ No
	e) Have you ever had an abnormal test result, without subsequent investigation establishing a normal test result, from any of the following tests: mammogram, breast imaging test, CT scan, PET scan, blood test to diagnose cancer, colonoscopy, ultrasound, PAP test or PSA test?	○ Yes ○ No
5.4	**Your family history**	
	Has a member of your immediate family (father, mother, siblings) been diagnosed or treated, before the age of 60, with cancer, heart disease, stroke (CVA), transient ischemic attack (TIA), Diabetes, Alzheimer's disease, Huntington's chorea, Parkinson's disease, Polycystic kidney disease (PKD), other kidney disease, Motor Neuron disease such as but not limited to ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease, Multiple sclerosis, or a hereditary disease or disorder?	○ Yes ○ No
5.5	**Your weight**	
	Is your weight greater than indicated for your height in the following table?	○ Yes ○ No

Height		Weight	
4'8" - 4'10"	142 - 147 cm	179 lbs	81 kg
4'11" - 5'1"	148 - 155 cm	198 lbs	90 kg
5'2" - 5'4"	156 - 163 cm	218 lbs	99 kg
5'5" - 5'7"	164 - 170 cm	239 lbs	108 kg

Height		Weight	
5'8" - 5'10"	171 - 178 cm	261 lbs	118 kg
5'11" - 6'1"	179 - 185 cm	284 lbs	129 kg
6'2" - 6'4"	186 - 193 cm	308 lbs	140 kg
6'5" - 6'7"	194 - 201 cm	332 lbs	151 kg

5.6	**Your smoking status**	
	Within the last 12 months have you used by any means a substance or product containing nicotine (except for a cigar 12 times or less in the last 12 months) or used electronic cigarettes or electronic vaping device or used marijuana more than four times per week? *If yes, smoker rates will apply.*	○ Yes ○ No
5.7	**Your current or planned insurance**	
	Do you have critical illness insurance coverage in effect on your life or have you applied for life, disability or critical illness insurance in the last 6 months or have a pending application with another insurance carrier or have you ever been denied or rated for life, disability or critical illness insurance coverage?	○ Yes ○ No

6. Payment Information

6.1 Payor is: ○ Insured ○ Owner ○ Other (provide details in section 6.3)

First Premium Payment: **Pre-authorized Debit (PAD):** ○ Monthly ○ Annual ○ **Cheque**[8] (payable to Foresters):$

Subsequent Premium(s): **Pre-authorized Debit (PAD):** ○ Monthly ○ Annual ○ **Direct Bill** (Annual)

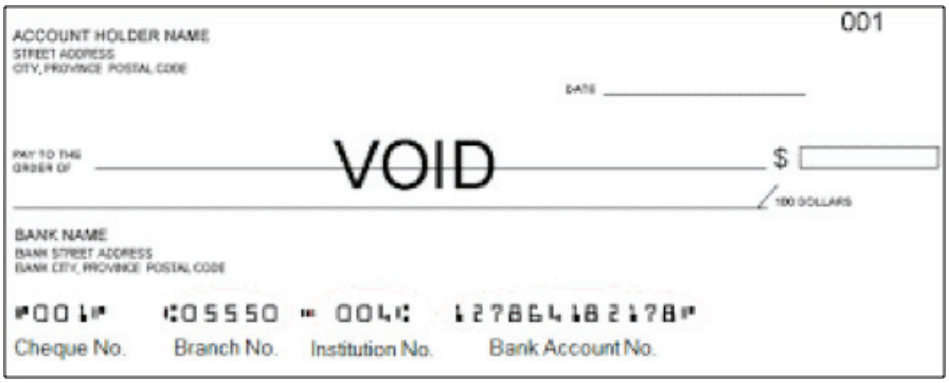
Preferred Draft Date: ○ No (monthly draw based on policy date) ○ Yes, draft on: ○ 1st ○ 8th ○ 15th ○ 22nd

PAD Banking Information: ○ Bank Information below ○ Attached Void Cheque* ○ Same as Foresters policy:

Transit (Branch) Number	Bank (Institution) Number	Bank Account Number

Name of Financial Institution	Account Type: ○ Chequing ○ Savings

Or Attach Void Cheque



*First premium payment cheque can be used as the void cheque

6.2 Pre-authorized Debit Plan Agreement

For purposes of this Agreement "Insurer" means Foresters Life Insurance Company; "Insurance Contract" means an insurance contract issued by the Insurer.

The payor, by signing below, verifies that the payor is an account holder of the account identified on the attached VOID cheque or in 6.1 of this Application for Live Well Critical Illness Insurance ("Application") and agrees that:

1) The Insurer issuing an Insurance Contract is authorized to make deductions monthly under this Agreement from that account or another account later identified or substituted by the payor for premiums and/or other payments for each Insurance Contract issued by the Insurer in response to this Application, such as for additional coverage or loan repayment(s);
2) The financial institution from which the deductions are 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 options, 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; and
7) The payor may contact the Insurer at:
Attention: Policy Owner Services; Foresters, 789 Don Mills Road, Toronto, ON M3C 1T9, 800-828-1540

The payor waives the right to receive pre-notification of: (i) the amount and date of the first deduction and any subsequent deductions; (ii) a change in the deduction amount for each Insurance Contract in effect; and (iii) a change in amount requested by the payor by whatever means.

For electronic PAD agreements only: The payor and payee agree to reduce the period for providing the written confirmation of the PAD agreement to three (3) calendar days before the first deduction.

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

Monthly and annual deductions under this Agreement are: ○ Personal ○ Business Related

X _____ on _____
(Signature of account holder) Date (mmm/dd/yyyy)

6.3 Payor/Third Party Information

(Complete section 6.3 only if payor is different from Insured or Owner or a Third Party is involved) If there are several third parties to be disclosed, complete a separate Third Party Determination form 105815 CAN for each one.

Is a third party involved with this application for insurance or will a third party pay the insurance premiums? ..... ○ Yes ○ No
If "Yes" complete this section 6.3

Full Legal Name of Individual (First, Middle, Last) or Corporation/Entity		
Type of Entity (if applicable)	Relationship to Owner	Date of Birth (mmm/dd/yyyy)
Detailed Occupation or Nature of Business		
Registration Number if Corporation	Jurisdiction of Incorporation	
Address (Street Number and Name)		
City	Province	Postal Code

If unable to provide the information above about the payor/third party, provide details as to why:

6.4 Additional Instructions

Issue each policy and future communications in ..... ○ English ○ French

Additional Instructions:

7. Agreements and Authorizations

7.1 Agreement

"Application" means this Foresters Application for Live Well Critical Illness Insurance. "I/me" means individually each person identified in this Application as the insured and/or owner. "Insurance Contract" means an insurance contract issued by the Insurer. "Insurer" means Foresters Life Insurance Company.

I, by signing this Application, understand and agree that:

1. The statements and answers contained in this Application, 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. There is no temporary coverage. An insurance contract issued, if any, by the Insurer will only come into effect according to the terms of that insurance contract that may include factors such as the date the Application was approved, the policy date, payment of the first premium and provided there is no change in insurability as described in the insurance contract.
3. No advisor, medical examiner or any other person has authority to advise that any untrue or incomplete answer or information is acceptable and has no power, except for Foresters President or Executive Secretary, or successor positions, to make, modify or discharge an insurance contract.
4. The language of an insurance contract issued as a result of this Application and all correspondence shall be the same as that of this Application unless otherwise requested in Section 6.4.
5. I, Owner, have received a copy of the Notices page, or if a proposed insured who is not an Owner I have reviewed the Notice Regarding MIB contained on the Notices page, however, if this is an InsuranceAssist electronic Application I, as an Owner or proposed insured, understand that the Notices page will instead be available electronically as part of the electronic signature process.

I further understand and agree that:

a) 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 cancellation period. Such changes or corrections may be made directly on this Application or by an amendment to this Application.

b) This Application and related documents may be completed, signed and/or submitted to each Insurer by voice and/or electronic means, including but not limited to, e-mail and facsimile transmission.

c) The Insurer 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.

d) If I have chosen to provide an email address or other electronic contact information in this Application or choose to provide such address or contact information in the future, the Insurer may use that address or contact information to send messages, information or documents to me electronically relating, directly or indirectly, to this Application, the Insurer, an insurance contract, membership, benefit claim, administration or other goods and services.

e) The Insurer's 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.

7.2 Authorization

The following definitions apply for purposes of this Authorization: "Application", "I/me", "Insurer" and "Insurance Contract" have the same meaning as defined in the Agreement subsection of this Application. "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, 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 or this Application, insurance contract, benefit claim, membership, business analysis or operations or management of the respective business of each.

"Authorized Purpose" means: assessing or servicing or administering insurance coverage, insurance contract, claim, membership or for identity verification, auditing, investigations, data loss analysis, compliance; tax reporting; informing of the benefits of membership; supporting business analysis and operations; record keeping; to assess and offer other products and services; any other purpose as required or permitted by law.

Your consent in relation to offering other products and services is optional.

If you do not want to provide your consent for that purpose, check here ○
or write to our Chief Privacy Officer at: Foresters, 789 Don Mills Rd., Toronto, ON M3C 1T9

I, by signing this Application, authorize the collection and use of information about me, by an Authorized Person for an Authorized Purpose, from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan, Foresters membership provider; other insurer or institution; public records; or MIB, Inc.

I, by signing this Application, authorize an Authorized Person to make a brief report about my personal health information to MIB Inc., 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 critical illness, 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, report to MIB Inc. if previously authorized to do so, or to inform of or administer the benefits of membership.

Consent for electronic delivery of the insurance contract and related documents.

In lieu of receiving paper, do you, the Owner signing below, consent to the electronic delivery of the insurance contract and related documents sent to the email address shown for you in this Application. ○ Yes ○ No

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

X _____

(Signature of Insured) Signed in Province Date (mmm/dd/yyyy)

X _____

(Signature of Owner – If other than Insured) Signed in Province Date (mmm/dd/yyyy)

8. Advisor's Report

Advisor's Name	Advisor Code	Agency Code	Split %

MGA Name	MGA Code	Affix MGA stamp, if applicable
MGA Office Contact Person	Contact Phone #	
MGA Office Contact Email		

1. How was this application completed? (please check one)

   ○ With the Owner in person
   ○ Telephone and/or Mail
   ○ Video Conference (for example: Skype/Zoom)
   ○ e-App/InsuranceAssist

2. Is this policy being purchased with the intent of transferring ownership in the policy? ..... ○ Yes ○ No
   If 'Yes', provide details:

3. Do you know of any information not disclosed in this application that could impact the insurability of the Insured or information that is different or incomplete from that provided in the application? ... ○ Yes ○ No
   If "Yes", provide details:

4. List the length of time you have known the Insured?	○ Less than 1 month ○ Month(s) _____ ○ Year(s)
5. If you are related to the Insured, list the nature of your relationship.	

Advisor's Comments:

I provided to the Insured the Notices page, however, if this is an InsuranceAssist electronic Application, the Notices will instead be available as part of the electronic signature process. Regardless of application method, I provided the Owner 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 insurance Application that has not been disclosed in this Application or advisor's report.

I have made a reasonable effort to determine if the Owner is acting on behalf of a third party. If I suspect that an undisclosed third party is involved, I will within a reasonable time email the details to askcompliance@foresters.com.

X _____
(Signature of Advisor who completed this Application and Advisor's Report) Date (mmm/dd/yyyy)

X _____
(Signature of Training Supervisor where required) Date (mmm/dd/yyyy)

Detach this page and leave with Owner

Notices

Notice Regarding MIB

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however make a brief report on it to MIB Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If a person named in this Application applies to another MIB member company for life, disability or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that 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 about your in its file. If you question the accuracy of the information about you in the MIB file, you may contact MIB and seek a correction. The address of MIB's information office is: MIB, 330 University Avenue, Toronto, Ontario M5G 1R7. Its telephone number is 416-597-0590 and website is www.mib.com.

Your Personal Information and Your Privacy

Respecting your privacy is important to us at Foresters. 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, 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 for Live Well Critical Illness Insurance signed by you. We will restrict access to your file to our employees, service providers, representatives, parent, 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. The Insurer's 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 Chief Privacy Officer at 789 Don Mills Road, Toronto, Ontario, M3C 1T9. To access our most recent Privacy Policy, please visit our website at www.foresters.com.

Advisor Disclosure Statement

The advisor identified in the Application for Live Well Critical Illness Insurance in an independent licensed insurance advisor authorized by Foresters Life Insurance Company to take an application in relation to the product you applied for in that Application and that is offered by that Insurer. If the Insurer issues a policy in response to the Application, the advisor will be entitled to receive compensation from that Insurer that may include first year and/or annual service commission, bonuses, conference programs or other incentives.

Making an Informed Decision

If you want more information about the insurance coverage you are considering, you can view a sample policy at **foresters.com/en-ca/for-advisors/sample-contracts** Your insurance advisor can answer any questions you may have.

About Foresters Financial™

Since 1874, Foresters Financial has been providing socially responsible financial services to individuals and families. Foresters Financial includes The Independent Order of Foresters, the oldest non-denominational fraternal benefit society. Foresters is a purpose-driven organization that exists to enrich family and community well-being and offers insurance products to over three million members and clients in Canada, the US and the U.K.