

Application for life and critical illness insurance

Use this application to apply for:

- Term 10 Life insurance
- Term 20 Life insurance
- Term 30 Life insurance
- Live Well Plus Critical Illness insurance
- Advantage Plus Participating Whole Life insurance
- Non-Par Whole Life insurance

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.

The Independent Order of Foresters
Foresters Life Insurance Company
789 Don Mills Road, Toronto, ON, Canada M3C 1T9
800 828 1540

Foresters Financial and Foresters are trade names and trademarks of The Independent Order of Foresters (a fraternal benefit society, 789 Don Mills Road, Toronto, Ontario, Canada M3C 1T9) and its subsidiaries.

How to use this application

You can use this application to apply for up to 4 policies provided that:

- You are applying for policies on no more than two lives (excluding the children insured under a Children's Term rider or a Juvenile Critical Illness insurance rider);
- The individuals to be insured are family members living in the same household;
- There are no more than two policy owners listed on the application; and
- Every policy has the same premium payor.

If you are applying for more than one policy with this application

You must complete **Section 1.6** and a separate **Section 2** for each additional policy. To designate a different beneficiary for a policy or for a term rider, please complete a separate beneficiary designation Section 1.7 and attach it to this application.

When you will need more than one application form

When the individuals to be insured are not family members living in the same household. When applying for a policy that has a different Owner than the Owners specified in this application, or any policy that has a different premium payor.

Attach an illustration for each policy applied for

An illustration is required for Advantage Plus Life Insurance. The illustration may be signed on delivery, but an unsigned illustration must be submitted with the application to ensure accurate processing. Submitting an illustration for term and critical illness insurance, while not required, will also facilitate more accurate processing. As the illustration is not part of any policy that may be issued, it cannot be accepted as a substitute for completing any part of this application.

Proof of valid e-signature

If the application is e-signed but not submitted through an approved Foresters e-application service, you will need to include proof satisfactory to Foresters (like a certificate of completion or evidence summary) from the e-signature vendor with your application submission.

Applications received in good order receive priority service

To ensure priority service:

- Complete the application in full, including any applicable supplementary forms, and ensure all questions are answered.
- Submit applicable disclosure forms if replacing existing life insurance.
- Cheques are payable to **Foresters**.
- If making a lump sum premium payment of \$100,000 or more for a permanent life insurance policy, complete a Politically Exposed Person Questionnaire form 105817 CAN.
- Print legibly in dark ink. Do not use ditto marks. Do not make erasures or use liquid paper. If you stroke out an error, it must be initialed by each person signing the application.
- To sign as an Insured, the applicant must be at least 16 years old, or at least 18 in Quebec. The signature of Insured Child under Children's Term Rider Required is required if an insured child is at least 16 years old, or at least 18 in Quebec.
- Detach the Important Notices page from the application and leave it with the Owner.

Application for Life Insurance & Critical Illness Insurance

1.1 Insured 1 – Personal details			
First name	Middle name	Last name	Male Female
Date of birth (mmm/dd/yyyy)		Country of birth	Province/State of birth
Social insurance number ¹			
Street address			
City	Province	Postal code	Foresters Member? Yes No, applying for membership
Primary telephone	Alternate telephone	Email address ²	
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
Employment details			
<i>If self-employed, or business owner, specify nature of business and duties. If not working, indicate reason, duration, and last occupation.</i>			
Occupation and duties:			
Name of employer:			
Length of employment:			
What is your annual earned income from employment, including self-employment?	\$		
What is your annual income from other sources?	\$		
Provide details of the source of these funds (RRIFs, Trusts, Dividends, etc...):			
If you are not self-supporting, what is your household annual earned income?	\$		
If you are not self-supporting, how much life insurance does the main provider of the household have?	\$		
What is the gross amount of your personal assets?	\$		
What is the amount of your outstanding debts?	\$		
In the last 5 years, have you declared or been petitioned into personal or corporate bankruptcy?	Yes		No
If yes, specify date discharged (mmm/dd/yyyy):			
Provide details/circumstances of bankruptcy:			

- SIN required only if the Insured will be an Owner and is applying for permanent life insurance.
- 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.

1.2 Insured 2 – Personal details

Type:	Joint policy	Spousal rider	Separate policy
First name	Middle name	Last name	Male Female
Date of birth (mmm/dd/yyyy)	Country of birth	Province/State of birth	
Social insurance number ¹	Same address as: Insured 1		
Street address (do not complete street address, city, province & postal code if address the same as Insured 1)			
City	Province	Postal code	Foresters Member? Yes No, applying for membership
Primary telephone	Alternate telephone	Email address ²	
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
Insured 2 – Employment details			
<i>If self-employed, or business owner, specify nature of business and duties. If not working, indicate reason, duration, and last occupation.</i>			
Occupation and duties:			
Name of employer:			
Length of employment:			
What is your annual earned income from employment, including self-employment?	\$		
What is your annual income from other sources?	\$		
Provide details of the source of these funds (RRIFs, Trusts, Dividends, etc...):			
If you are not self-supporting, what is your household annual earned income?	\$		
If you are not self-supporting, how much life insurance does the main provider of the household have?	\$		
What is the gross amount of your personal assets?	\$		
What is the amount of your outstanding debts?	\$		
In the last 5 years, have you declared or been petitioned into personal or corporate bankruptcy?	Yes No		
If yes, specify date discharged (mmm/dd/yyyy):			
Provide details/circumstances of bankruptcy:			

1. SIN required only if the Insured will be an Owner and is applying for permanent life insurance.

2. 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.

1.3 Owner 1 (An Owner must be at least 16 years old except must be at least 18 in Quebec)			
Owner is: Insured 1 (skip to Contingent Owner) Other individual or entity – complete this section 1.3 below		Insured 2 (skip to Contingent Owner)	
Full legal name of individual (first, middle, last) or corporation/entity			Male Female
Social insurance number ³		Same address as: Insured 1 Insured 2	
Address (do not complete address, city, province & postal code if the same as Insured 1 or 2)			Date of birth (mmm/dd/yyyy)
City		Province	Postal code
Primary telephone		Alternate telephone	Relationship to Insured
Occupation		Email address ⁴	
If Trust, name of trustee			If Trust, date of trust agreement
Contingent Owner for Owner 1: (Optional)			
Full legal name (first, middle, last) or corporation/entity		Date of birth (mmm/dd/yyyy)	Relationship to Owner
Owner 1 verification			
To comply with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act, the identity of Owners must be verified and the involvement of any third parties determined in section 1.5. For a document to be acceptable for identification purposes, it must have a photo, a unique identifier number and must have been issued by a provincial, territorial or federal government.			
Document presented to verify identity: Driver's licence Passport Other, specify:			
Document number		Jurisdiction of issue	Expiry date (mmm/dd/yyyy)
Tax information (complete only if applying for permanent life insurance)			
To comply with the Canada-U.S. Enhanced Tax Information Exchange Agreement, Canadian financial institutions are required by law to report information to the Canada Revenue Agency (CRA) on certain financial accounts held in Canada by U.S. persons. You have an obligation to notify us of any change in tax residency status.			
Are you a U.S. resident for U.S. tax purposes or a U.S. citizen?			Yes No
If yes, provide your U.S. Tax Identification Number (TIN).			
To comply with part XIX of Canada's Income Tax Act, Canadian financial institutions are required by law to report information to the CRA on certain financial accounts in Canada held by tax residents of jurisdictions other than Canada or the US.			
Are you a resident for tax purposes of any jurisdiction other than Canada and the US?			Yes No
If 'yes', provide all of your jurisdictions of tax residence and each respective Taxpayer Identification Number (TIN):			
Jurisdiction of tax residence:		TIN:	
If you do not have a TIN for any jurisdiction of tax residence then please choose one of the following codes for each such jurisdiction:		A: You have applied for a TIN but have not yet received it B: That jurisdiction of tax residence does not issue TINs to its residents C: Other (please specify reason):	

3. SIN required only if the Owner is applying for permanent life insurance.

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

1.4 Owner 2 (An Owner must be at least 16 years old except must be at least 18 in Quebec)			
Owner is: Insured 1 (skip to Contingent Owner) Other individual or entity – complete this section below		Insured 2 (skip to Contingent Owner)	
Full legal name of individual (first, middle, last) or corporation/entity			Male Female
Social insurance number ³		Same address as: Insured 1 Owner 1 Insured 2	
Address (do not complete address, city, province & postal code if the same as Insured 1 or 2 or Owner 1)			Date of birth (mmm/dd/yyyy)
City		Province	Postal code
Primary telephone		Alternate telephone	Relationship to Insured
Occupation		Email address ⁴	
If Trust, name of trustee			If Trust, date of trust agreement
Contingent Owner for Owner 2: (Optional)			
Full legal name (first, middle, last) or corporation/entity		Date of birth (mmm/dd/yyyy)	Relationship to Owner
Owner 2 verification			
To comply with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act, the identity of Owners must be verified and the involvement of any third parties determined in section 1.5. For a document to be acceptable for identification purposes, it must have a photo, a unique identifier number and must have been issued by a provincial, territorial or federal government.			
Document presented to verify identity: Driver's licence Passport Other, specify:			
Document number		Jurisdiction of issue	Expiry date (mmm/dd/yyyy)
Tax information (complete only if applying for permanent life insurance)			
To comply with the Canada-U.S. Enhanced Tax Information Exchange Agreement, Canadian financial institutions are required by law to report information to the Canada Revenue Agency (CRA) on certain financial accounts held in Canada by U.S. persons. You have an obligation to notify us of any change in tax residency status.			
Are you a U.S. resident for U.S. tax purposes or a U.S. citizen?			Yes No
If yes, provide your U.S. Tax Identification Number (TIN).			
To comply with part XIX of Canada's Income Tax Act, Canadian financial institutions are required by law to report information to the CRA on certain financial accounts in Canada held by tax residents of jurisdictions other than Canada or the US.			
Are you a resident for tax purposes of any jurisdiction other than Canada and the US?			Yes No
If 'yes', provide all of your jurisdictions of tax residence and each respective Taxpayer Identification Number (TIN):			
Jurisdiction of tax residence:		TIN:	
If you do not have a TIN for any jurisdiction of tax residence then please choose one of the following codes for each such jurisdiction:		A: You have applied for a TIN but have not yet received it B: That jurisdiction of tax residence does not issue TINs to its residents C: Other (please specify reason):	

3. SIN required only if the Owner is applying for permanent life insurance.

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

1.5 Third Party determination (required if applying for permanent insurance)

A third party is an individual or entity with or will have an interest in a policy but is not an Insured or an Owner. Some examples of third parties include: premium payor, power of attorney, executor, and trustee.

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 policy applied for? If the answer is yes, provide the following information:	Yes	No
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Full legal name of third party (first, middle, last), or corporation/entity	Date of birth (mmm/dd/yyyy)
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Type of third party	Relationship to Owner(s)
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Detailed occupation or nature of business

Street address

City	Province	Postal code
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Registration number if a corporation	Jurisdiction of incorporation
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If unable to provide the information above about a third party, provide details as to why:

If there are several third parties to be disclosed, complete a separate Third Party Determination form 105815 CAN for each one.

1.6 Multiple policies

You must complete this section if you are applying for more than one policy with this application. You must also complete a separate Section 2 for each policy applied for. As an illustration is not part of any policy that may be issued, it cannot be accepted as a substitute for completing any part of this application.

	Base insurance plan	Base plan amount	Insured under the base plan	Policy Owner
Policy A	Whole Life : Advantage Plus Non Par Term : T10 T20 T30 Live Well Plus : T10 T20 T80	\$	Insured 1 Insured 2	Owner 1 Owner 2
Policy B	Whole Life : Advantage Plus Non Par Term : T10 T20 T30 Live Well Plus : T10 T20 T80	\$	Insured 1 Insured 2	Owner 1 Owner 2
Policy C	Whole Life : Advantage Plus Non Par Term : T10 T20 T30 Live Well Plus : T10 T20 T80	\$	Insured 1 Insured 2	Owner 1 Owner 2
Policy D	Whole Life : Advantage Plus Non Par Term : T10 T20 T30 Live Well Plus : T10 T20 T80	\$	Insured 1 Insured 2	Owner 1 Owner 2

1.7 Beneficiaries

Revocable/Irrevocable designations: All 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. Do not name a minor as an irrevocable beneficiary. Once an irrevocable beneficiary has been named, his or her written consent is required for changes as described in 3 below; a minor cannot give that consent. For Live Well Plus, a beneficiary designation is only for the Return of Premium on Death Benefit. A critical illness benefit payable is paid to the Owner.

- List the beneficiary relationship to the Insured (except in Quebec). In Quebec, list the beneficiary relationship to the Owner.
- Primary and Contingent Beneficiary Designations must total 100% respectively.
- 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.
- 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.

Beneficiaries – Policy A:

Name	Type	Relationship	Date of birth	Share %	Beneficiary
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable

If Beneficiary is a minor

Name	Trustee name	Relationship of Trustee to Owner
1.		
2.	Same as Minor 1	
3.	Same as Minor 1 Same as Minor 2	
4.	Same as Minor 1 Same as Minor 2	

Beneficiaries – Policy B:

Name	Type	Relationship	Date of birth	Share %	Beneficiary
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable

If Beneficiary is a minor

Name	Trustee name	Relationship of Trustee to Owner
1.		
2.	Same as Minor 1	
3.	Same as Minor 1 Same as Minor 2	
4.	Same as Minor 1 Same as Minor 2	

Beneficiaries – Policy C:					
Name	Type	Relationship	Date of birth	Share %	Beneficiary
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
If Beneficiary is a minor					
Name	Trustee name		Relationship of Trustee to Owner		
1.					
2.	Same as Minor 1				
3.	Same as Minor 1	Same as Minor 2			
4.	Same as Minor 1	Same as Minor 2			

Beneficiaries – Policy D:					
Name	Type	Relationship	Date of birth	Share %	Beneficiary
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
	Primary Contingent				Revocable Irrevocable
If Beneficiary is a minor					
Name	Trustee name		Relationship of Trustee to Owner		
1.					
2.	Same as Minor 1				
3.	Same as Minor 1	Same as Minor 2			
4.	Same as Minor 1	Same as Minor 2			

1.8 Charity Benefit beneficiary designation (For Term and Advantage Plus only)

Each Term & Advantage Plus life insurance policy applied for will, if issued, include a Charity Benefit. The Owner(s) can designate an eligible beneficiary for that benefit now or at any time prior to the Insured's death. If an eligible beneficiary is not designated prior to the Insured's death, no Charity Benefit will be paid. Eligible beneficiary means an organization registered as a charity with the Canada Revenue Agency.

Charitable organization name		Registration number
Street Address		
City	Province	Postal code

Policy: A B C D

If applying for more than one policy with this application, please complete a separate Section 2, Page 8 for each additional policy.

2.1 Plan & benefit – Term Life			
Type	Single life	Joint first-to-die	
Amount of Insurance \$	Term 10	Term 20	Term 30
Term 10 Rider	Insured 1 \$		Insured 2 \$
Term 20 Rider	Insured 1 \$		Insured 2 \$
Term 30 Rider	Insured 1 \$		Insured 2 \$
Accidental Death Benefit	Insured 1 \$		Insured 2 \$
Children's Term Rider	Amount for each child: \$		
Waiver of Premium	Yes	No	
2.2 Plan & benefit – Live Well Plus Critical Illness Insurance			
Amount of Insurance \$	Live Well Plus T10	Live Well Plus T20	Live Well Plus T80
Optional Riders	Return of Premium on Surrender or Expiry Rider		Disability Waiver of Premium Rider
	Juvenile Critical Illness Rider \$		
2.3 Plan & benefit – Advantage Plus Participating Whole Life			
Basic: \$	Enhanced: \$	Total: \$	
Dividend options	Enhanced Insurance – complete the Enhanced and Total amounts above Paid Up Additions Dividends on Deposit Premium Reduction Cash Payment		
Premium payment period	Pay to 100	20-pay	10-pay
Term 10 Rider	Insured 1 \$		Insured 2 \$
Term 20 Rider	Insured 1 \$		Insured 2 \$
Term 30 Rider	Insured 1 \$		Insured 2 \$
Additional Payment Option (APO) (not available on 10-pay policies)	Single payment: \$ Scheduled payments: \$ Monthly Annual Scheduled payments amount, shown above, will be added to the premium for the policy to determine the amount of each bill, if annual billing, or of each draft, if monthly PAD, is elected for payment of premium.		
Children's Term Rider	Amount for each child: \$		
Accidental Death Benefit	\$		
Guaranteed Insurability	Yes	No	
Waiver of Premium	Yes	No	
Owner Waiver of Premium	Yes	No	
2.4 Plan & benefit – Non Par Whole Life			
Amount of Insurance \$	Single life	Joint first-to-die	Life pay 20-pay
	Joint last-to-die		
Term 10 Rider	Insured 1 \$		Insured 2 \$
Term 20 Rider	Insured 1 \$		Insured 2 \$
Term 30 Rider	Insured 1 \$		Insured 2 \$
Accidental Death Benefit	Insured 1 \$		Insured 2 \$
Children's Term Rider	Amount for each child: \$		
Waiver of Premium	Yes	No	

Policy: A B C D

If applying for more than one policy with this application, please complete a separate Section 2, Page 8 for each additional policy.

2.1 Plan & benefit – Term Life			
Type	Single life	Joint first-to-die	
Amount of Insurance \$	Term 10	Term 20	Term 30
Term 10 Rider	Insured 1 \$	Insured 2 \$	
Term 20 Rider	Insured 1 \$	Insured 2 \$	
Term 30 Rider	Insured 1 \$	Insured 2 \$	
Accidental Death Benefit	Insured 1 \$	Insured 2 \$	
Children’s Term Rider	Amount for each child: \$		
Waiver of Premium	Yes	No	
2.2 Plan & benefit – Live Well Plus Critical Illness Insurance			
Amount of Insurance \$	Live Well Plus T10	Live Well Plus T20	Live Well Plus T80
Optional Riders	Return of Premium on Surrender or Expiry Rider		Disability Waiver of Premium Rider
	Juvenile Critical Illness Rider \$		
2.3 Plan & benefit – Advantage Plus Participating Whole Life			
Basic: \$	Enhanced: \$	Total: \$	
Dividend options	Enhanced Insurance – complete the Enhanced and Total amounts above Paid Up Additions Dividends on Deposit Premium Reduction Cash Payment		
Premium payment period	Pay to 100	20-pay	10-pay
Term 10 Rider	Insured 1 \$	Insured 2 \$	
Term 20 Rider	Insured 1 \$	Insured 2 \$	
Term 30 Rider	Insured 1 \$	Insured 2 \$	
Additional Payment Option (APO) (not available on 10-pay policies)	Single payment: \$ Scheduled payments: \$ Monthly Annual Scheduled payments amount, shown above, will be added to the premium for the policy to determine the amount of each bill, if annual billing, or of each draft, if monthly PAD, is elected for payment of premium.		
Children’s Term Rider	Amount for each child: \$		
Accidental Death Benefit	\$		
Guaranteed Insurability	Yes	No	
Waiver of Premium	Yes	No	
Owner Waiver of Premium	Yes	No	
2.4 Plan & benefit – Non Par Whole Life			
Amount of Insurance \$	Single life	Joint first-to-die	Life pay 20-pay
	Joint last-to-die		
Term 10 Rider	Insured 1 \$	Insured 2 \$	
Term 20 Rider	Insured 1 \$	Insured 2 \$	
Term 30 Rider	Insured 1 \$	Insured 2 \$	
Accidental Death Benefit	Insured 1 \$	Insured 2 \$	
Children’s Term Rider	Amount for each child: \$		
Waiver of Premium	Yes	No	

3.1 Purpose of insurance

What are the main purposes of this insurance? Select all that apply.

Income replacement	Estate preservation	Loan protection
Buy-sell coverage	Key person insurance	Other, specify below:

Details:

3.2. Insurance history

Ensure all disclosure requirements are completed if this application for life insurance is intended to replace existing insurance. Note that it is considered a replacement if you are replacing a Foresters policy with another Foresters policy.

Do you have individual life, accidental death, critical illness or disability insurance in force or pending with Foresters or another insurer? If yes, complete the following table:

					Insured 1		Insured 2	
					Yes	No	Yes	No
Insurer	Status	Year issued	Type of insurance	Category	Insured		Amount	
	In-force Pending			Personal Business	Insured 1 Insured 2	\$		
	In-force Pending			Personal Business	Insured 1 Insured 2	\$		
	In-force Pending			Personal Business	Insured 1 Insured 2	\$		
	In-force Pending			Personal Business	Insured 1 Insured 2	\$		

If you have pending life or critical illness insurance with other carriers, how much of the total insurance will be placed with those carriers?

	Insured 1	Insured 2
Life insurance	\$	\$
Critical Illness insurance	\$	\$

Will you stop paying premiums, reduce the amount of coverage or discontinue existing life insurance coverage or an annuity if the insurance applied for in this application is issued?

If yes, specify details below, and complete the Comparison Disclosure Statement or Life Insurance Replacement Declaration required in your province.

Insured	Plan	Insurer	Amount
Insured 1 Insured 2			\$
Insured 1 Insured 2			\$
Insured 1 Insured 2			\$

Have you ever had an application for life, critical illness or disability insurance declined, rated, or modified? If yes, specify the insurer, the date and final decision below.

Insured	Declined Modified	Rated	Reason:	Insurer: Type: Date:
Insured 1				
Insured 2				

Lifestyle questions					
		Insured 1		Insured 2	
3.3 Foreign Residency & Travel	Do you expect, within the next 2 years, to change your residence from Canada or to travel outside of Canada or the United States, Caribbean Islands (excluding Haiti), Western Europe, Hong Kong, Australia or New Zealand? If yes to this question, please provide details in Section 3.11 including the name of each country, total number of weeks per year spent in each country, and purpose of each trip.	Yes	No	Yes	No
3.4 Criminal Offences	Have you ever been charged or convicted of a criminal offence? If yes, identify and provide details for each charge and conviction in Section 3.11.	Yes	No	Yes	No
3.5 Medications, drugs and alcohol	In the last 10 years, have you used a narcotic or controlled drug except as prescribed to you by a physician? If yes, complete a Drug Usage questionnaire	Yes	No	Yes	No
	In the last 3 years, have you consumed alcoholic beverages? If yes, specify: How many times per week? How many drinks per occasion?	Yes	No	Yes	No
	Have you ever received or been offered or advised to receive treatment or counseling for, or to discontinue or reduce the use of, alcohol or drugs? If yes, complete the applicable Alcohol or Drug Usage Questionnaire.	Yes	No	Yes	No
3.6 Smoking & Tobacco Use	When was the last time you used tobacco or nicotine based products or smoking cessation aids? never in the last 12 months in the last 24 months in the last 5 years				
	If you only smoke cigars, how many have you smoked in the last 12 months? Not applicable 4 or less 5 to 12 more than 12				
	In the last 5 years have you used marijuana or hashish? If yes, please describe your usage: 1-3 times per week 4-6 times per week 7 times per week? (once per day) 8 or more times per week	Yes	No	Yes	No
3.7 Driving If incomplete dates and details are provided, a follow-up will be required for preferred underwriting classification.	Within the last ten years have you been charged or convicted of an alcohol or drug related driving offence, refusing a breathalyzer, had your driver's licence suspended or revoked or, excluding parking violations, had more than one driving offence? If yes to this question, provide month, year and details for each charge in Section 3.11. For speeding violations, provide number of kilometers over the limit. Provide driver's licence number and place of issue if not provided in Section 1.3.	Yes	No	Yes	No
3.8 Aviation	In the last 2 years have you flown, or do you plan to fly, an aircraft as a pilot, student pilot or crew member? If yes, submit a completed Aviation Questionnaire.	Yes	No	Yes	No
3.9 Avocations	In the last 2 years have you engaged in, or do you plan to engage in, any of the following: Motorized racing, sky diving, scuba diving, hang gliding, mountain climbing, heli-skiing, CAT or back country skiing or snowboarding, or any other hazardous or extreme activity or sport?	Yes	No	Yes	No

Lifestyle questions continued

		Insured 1		Insured 2	
3.10 Assisted living	Do you reside in a nursing home or nursing facility, assisted living residence, retirement home or senior living facility?	Yes	No	Yes	No
	Due to a chronic illness or disease, do you require the use of a wheelchair or are you bedridden?	Yes	No	Yes	No
	Require assistance with any of the following activities of daily living: taking medications, bathing, dressing, eating, or toileting?	Yes	No	Yes	No

3.11 Additional details

Question	Insured	Details
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	
	Insured 1 Insured 2	

4.1 Insured is a minor		
	Parent 1	Parent 2
What is the gross annual income earned by the minor's parents/legal guardian?	\$	\$
How much life and critical illness insurance do the minor's parents/legal guardian have? If none – indicate why not under details below.	\$	\$
How much life and critical illness insurance do the minor's siblings have? No siblings None – indicate in detail why this application is being made to insure this minor.	Life Insurance	Critical Illness
Sibling 1	\$	\$
Sibling 2	\$	\$
Sibling 3	\$	\$
Sibling 4	\$	\$
Sibling 5	\$	\$
Detail		

4.2 Business insurance			
Corporation	Partnership	Sole Proprietorship	Other
Nature of the business			Year established
Assets \$	Liabilities \$	Share of ownership Insured 1: % Insured 2: %	
Net worth \$	Business fair market value \$		
Gross annual revenue \$	Net annual income \$		
Do other executives or partners in the business have life or critical illness insurance related to the business? If no, provide reason why below:		Yes	No
If yes to the previous question, provide details below:			
Name			
Title			
% of business owned		%	%
Life insurance in force	\$	\$	
Life insurance pending	\$	\$	
Critical Illness insurance in force	\$	\$	
Critical Illness insurance pending	\$	\$	
In the last 5 years, has the business declared or been petitioned into bankruptcy?		Yes	No
If yes, specify date discharged (mmm/dd/yyyy)			

5.1 Insured 1 - Vitals & physician information

Height ft/in cm	Weight lbs kgs	Has your weight changed more than 10 lbs in the last 6 months? No Gain Loss Reason for weight change:
Do you have a regular physician?		Yes No If yes, provide details below:
Physician's name		Phone number
Street address		
City	Province	Postal code
Reason and result of last visit to regular physician?		Date of last visit (mmm/dd/yyyy)
In the last 5 years, have you seen a physician who is not your regular physician? If yes, provide the same details as above for each additional physician in Section 5.6.		Yes No

Insured 2 - Vitals & physician information

Height ft/in cm	Weight lbs kgs	Has your weight changed more than 10 lbs in the last 6 months? No Gain Loss Reason for weight change:
Do you have a regular physician?		Yes No If yes, provide details below:
Physician's name		Phone number
Street address		
City	Province	Postal code
Reason and result of last visit to regular physician?		Date of last visit (mmm/dd/yyyy)
In the last 5 years, have you seen a physician who is not your regular physician? If yes, provide the same details as above for each additional physician in Section 5.6.		Yes No

"You" and "your" in each of sections 5.2 - 5.6 means Insured 1 and Insured 2, individually, identified in Section 1.1 and 1.2.

5.2 Family history (optional if a paramedical exam is required)

Have either of your biological parents, brothers or sisters been diagnosed before age 65 with Alzheimer's disease, Cancer, Huntington's chorea, Diabetes, Parkinson's disease, Heart disease, Polycystic kidney disease, stroke, multiple sclerosis, motor neuron disease, or any other inherited disease, disorder or condition not listed in Section 5.2				Insured 1 Yes No Unknown	Insured 2 Yes No Unknown
Insured	Relationship	Condition (if cancer, specify type)	Age at onset	Age if living	Age at death
Insured 1 Insured 2					
Insured 1 Insured 2					
Insured 1 Insured 2					
Insured 1 Insured 2					
If unknown, specify a reason:					

5.3 Personal medical history (optional if a paramedical exam is required)

Do not provide any information about genetic testing or genetic test results.

Have you ever had, been diagnosed with, or received treatment or medication, tested positive or been given medical advice for:	Insured 1		Insured 2	
A Chronic Obstruction Pulmonary Disease (COPD), emphysema, cystic fibrosis, asthma, shortness of breath, a disease or disorder of the respiratory system or do you require the use of oxygen equipment?	Yes	No	Yes	No
B Diabetes, abnormal blood sugar or Hemoglobin A1c, or complications of diabetes such as retinopathy (complete or partial loss of sight in either eye), neuropathy (nerve pain, tingling or burning in any part of your extremity such as a hand, finger, foot, toe) or nephropathy (abnormal lab results related to the kidney(s) or chronic kidney disease of any stage)?	Yes	No	Yes	No
C Epilepsy, seizure, stroke, transient ischemic attack (TIA), developmental disorder, Huntington's disease, or a neurological disorder?	Yes	No	Yes	No
D Amyotrophic lateral sclerosis (Lou Gehrig's disease), muscular dystrophy, dementia, cognitive impairment, memory loss, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, fibromyalgia, arthritis or a disease or disorder of the brain or nervous system?	Yes	No	Yes	No
E Anxiety, depression, manic depression, bipolar disorder, schizophrenia, or a mental health disorder?	Yes	No	Yes	No
F A heart attack, heart surgery, heart procedure, circulatory surgery, coronary artery disease, heart murmur, chest pain, irregular heartbeat, aneurysm, congestive heart failure (CHF), a disease or disorder of the arteries, or valves, high blood pressure, a peripheral vascular or arterial disease (PVD or PAD), or a disorder of the blood or lymphatic system?	Yes	No	Yes	No
G Blood in the urine, hepatitis, Crohn's disease, lupus, cirrhosis, or a disease or disorder of the liver, prostate, bladder, kidney, genito-urinary organs, connective tissue or digestive or immune system?	Yes	No	Yes	No
H Cancer (excluding basal cell carcinoma), tumour, gastrointestinal bleeding, unexplained weight loss or a disease or disorder of the pancreas or endocrine system?	Yes	No	Yes	No
I The Human Immunodeficiency Virus (HIV), acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or an immunological disorder?	Yes	No	Yes	No

5.4 Personal medical history continued (optional if a paramedical exam is required)

	Insured 1		Insured 2	
A Have you ever been advised to have a test such as an ECG, CT scan, bone scan, MRI, colonoscopy, echocardiogram, angiogram, biopsy or endoscopy?	Yes	No	Yes	No
B Have you ever been advised to have a checkup, consultation, take medication, get treatment, surgery, hospitalization, lab test or diagnostic test that has not yet started or been completed, or the results of which are not yet known?	Yes	No	Yes	No
C Are you currently taking medication or under treatment?	Yes	No	Yes	No
D Are you in need of an organ transplant, on a waiting list for an organ transplant, or the recipient of an organ transplant (excluding corneal transplants)?	Yes	No	Yes	No
E Have you ever been diagnosed with a life threatening, critical or terminal illness or condition for which a physician has estimated that you have 24 months or less to live?	Yes	No	Yes	No

Complete Section 5.5 only if applying for Critical Illness coverage.

5.5 Critical Illness specific medical history (optional if a paramedical exam is required)

Have you ever had, been diagnosed with or tested positive, or received medical advice, treatment or medication, for:	Insured 1		Insured 2	
A Vertigo, dizziness, optic neuritis, impaired hearing, loss of vision or any other disorder of the eyes, ear, nose or throat?	Yes	No	Yes	No
B Cyst, lump, polyp, leukemia, lymphoma or a growth or malignancy of any type?	Yes	No	Yes	No
C Dysplastic nevus syndrome, melanoma, basal cell carcinoma, atypical mole or a disease or disorder of the skin?	Yes	No	Yes	No
D Hyperthyroid, goiter, anemia or any other disease or disorder of the thyroid, adrenal or pituitary gland?	Yes	No	Yes	No

5.6 Personal medical history details

Additional details	Question	Insured	Details
Identify each condition, event, procedure, disease, disorder and illness for which you provided a "yes" answer in Sections 5.1 and Sections 5.3 through 5.5.		Insured 1 Insured 2	
		Insured 1 Insured 2	
Include dates, diagnoses, treatments, results and duration.		Insured 1 Insured 2	
Also provide the names and contact information for each medical professional.		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	
		Insured 1 Insured 2	

6.1 Children

Complete this section for each child proposed for insurance under a Children's term life insurance rider or Juvenile critical illness insurance rider. This section must be completed by a parent or guardian of each child named in Section 6.1. The parent or guardian must have full knowledge of each child's medical history and circumstances sufficient to answer all questions in Section 6 accurately.

Child 1 - Details

First name	Middle name	Last name
Date of birth (mmm/dd/yyyy)	Country of birth	Relationship to insured
Height ft/in cm	Weight lbs kgs	Sex Male Female
Reason and result of last visit to physician, other medical advisor, clinic or hospital?		Date of last visit (mmm/dd/yyyy)

Child 2 - Details

First name	Middle name	Last name
Date of birth (mmm/dd/yyyy)	Country of birth	Relationship to insured
Height ft/in cm	Weight lbs kgs	Sex Male Female
Reason and result of last visit to physician, other medical advisor, clinic or hospital?		Date of last visit (mmm/dd/yyyy)

Child 3 - Details

First name	Middle name	Last name
Date of birth (mmm/dd/yyyy)	Country of birth	Relationship to insured
Height ft/in cm	Weight lbs kgs	Sex Male Female
Reason and result of last visit to physician, other medical advisor, clinic or hospital?		Date of last visit (mmm/dd/yyyy)

Child 4 - Details

First name	Middle name	Last name
Date of birth (mmm/dd/yyyy)	Country of birth	Relationship to insured
Height ft/in cm	Weight lbs kgs	Sex Male Female
Reason and result of last visit to physician, other medical advisor, clinic or hospital?		Date of last visit (mmm/dd/yyyy)

Child 5 - Details

First name	Middle name	Last name
Date of birth (mmm/dd/yyyy)	Country of birth	Relationship to insured
Height ft/in cm	Weight lbs kgs	Sex Male Female
Reason and result of last visit to physician, other medical advisor, clinic or hospital?		Date of last visit (mmm/dd/yyyy)

6.2 Children’s medical history (answer question 6.2.i only if applying for Juvenile Critical Illness insurance rider)

“Child” means each child listed in section 6.1.

A Does a child reside at a different address than either Insured 1 or Insured 2? If yes, provide details below about whom the child lives with and how often each Insured sees the child.	Yes	No
B Has an insurance application on a child ever been declined, postponed or modified?	Yes	No
C Has a child had surgery or been hospitalized for more than 3 consecutive days at birth or later?	Yes	No
D Has a child been treated or tested for, or had a symptom or indication of autism, ADHD, asthma cancer, tumour or growth, cerebral palsy, cystic fibrosis, cystitis cystica, congenital abnormalities, heart disease, Down’s syndrome, muscular dystrophy, infectious disease or another disease, disorder or condition?	Yes	No
E Does a child have a delay in physical or mental development, or an impairment, disease, disorder, condition, or injury that requires follow-up testing, medication, treatment or surgery?	Yes	No
F Is a child currently on medication, or been advised to have medication, treatment, blood work, specialist consultation, x-ray, ultrasound, EKG, CT or MRI scan, biopsy, scope or diagnostic test that has not yet started or been completed, or the results of which are not yet known?	Yes	No
G Was a child born prematurely (less than 36 weeks)? If yes, identify the child and specify birth weight in Section 6.3.	Yes	No
H In the last 2 years has a doctor or health practitioner advised that a child’s height, weight or physical development were not meeting normal milestones, or advised that a child gain or lose weight? IF YES – Provide details: Height/Weight/ If there has been any weight loss in the last 12 months.	Yes	No
I Has a child’s biological mother, father or, sibling(s) been diagnosed before age 60 with cancer, heart attack, coronary artery disease, stroke, cardiomyopathy, diabetes, polycystic kidney disease, Huntington’s disease, Parkinson’s disease or cystic fibrosis? If yes, please complete the following table:	Yes	No

Relationship to child	Condition/Event/Disease (if cancer, be specific)	Onset age	Age if living	Age at death

6.3. Children’s medical history details (for any “yes” answers in section 6.2)

Question	Child’s name	Details

7.1 Owner Waiver of Premium for Advantage Plus					
Owner 1 Owner 2		Height ft/in cm		Weight lbs kgs	
		Owner 1		Owner 2	
7.2 Is the Owner currently employed full time? If no, state number of work hours per week if part-time. Indicate reason for and duration of not working full time, and last occupation in Section 7.8. If self-employed, or business owner, specify nature of business and duties in Section 7.8.		Yes	No	Yes	No
7.3 In the last 5 years, has the Owner:					
A Consulted a physician; had an electrocardiogram, diagnostic test, or been in a clinic, hospital or medical office for observation or treatment?		Yes	No	Yes	No
B Been advised to have a diagnostic test, hospitalization or surgery that has not yet started or been completed, or the results of which are not yet known?		Yes	No	Yes	No
7.4 Has the Owner ever had, been diagnosed with or tested positive, or received medical advice, treatment or medication, for:					
A A heart attack, heart surgery, heart procedure, circulatory surgery, coronary artery disease, heart murmur, chest pain, irregular heartbeat, aneurysm, congestive heart failure (CHF), a disease or disorder of the arteries or valves, a peripheral vascular or arterial disease (PVD or PAD), neuropathy (nerve pain, tingling or burning in any part of your extremity such as a hand, finger, foot or toe), Chronic Obstruction Pulmonary Disease (COPD), asthma, emphysema, or a disease or disorder of the respiratory system?		Yes	No	Yes	No
B Cancer (excluding basal cell carcinoma), tumour, gastrointestinal bleeding, unexplained weight loss, stroke, or TIA (transient ischemic attack) or a disease or disorder of the pancreas or endocrine system?		Yes	No	Yes	No
C Diabetes, glandular or thyroid disorder, enlarged lymph node, epilepsy or anxiety, depression, manic depression, bipolar disorder, schizophrenia, or a mental health disorder?		Yes	No	Yes	No
D Kidney, urinary or reproductive system disease or disorder, liver or gastrointestinal disorder, hepatitis or hepatitis carrier state?		Yes	No	Yes	No
E Loss of vision, retinopathy (complete or partial loss of sight in either eye), back pain requiring treatment or medication, amputation, deformity, arthritis, or a musculo-skeletal disease or disorder?		Yes	No	Yes	No
7.5 Has the Owner ever had, been diagnosed with, or received treatment or medication, tested positive or been given medical advice for the Human Immunodeficiency Virus (HIV), acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or an immunological disorder?		Yes	No	Yes	No
7.6 Is the Owner currently taking treatment or medication? If yes, provide details in Section 7.8.		Yes	No	Yes	No
7.7 Has the Owner:					
A Ever had a request for life or disability insurance declined, postponed, rated or restricted?		Yes	No	Yes	No
B Within the last two years, flown, or plan to fly, or taken instruction as a pilot or engaged, or plan to engage, in racing, scuba or sky diving, hang gliding or a hazardous or extreme sport or activity?		Yes	No	Yes	No
C Within the last five years used a narcotic or controlled drug except as prescribed by a physician, marijuana, or been advised to receive treatment, medical advice or counseling for, or to discontinue or reduce the use of, alcohol or a drug?		Yes	No	Yes	No
D Ever been charged or convicted of an alcohol or drug related driving offence, refusing a breathalyzer, had a driver's licence suspended or revoked or, excluding parking violations, had more than one driving offence??		Yes	No	Yes	No
E Plans to travel for more than four consecutive weeks or change residency from Canada?		Yes	No	Yes	No
7.8 Further details (required for any "yes" answers in section 7.2, 7.3, 7.4, 7.6 & 7.7)					
Question	Owner	Details			
	Owner 1 Owner 2				
	Owner 1 Owner 2				
	Owner 1 Owner 2				

8.1 Premium & issue instructions

If applying for multiple insurance policies, we will apply the premium payment and policy issue instructions to every policy specified in Section 1.6 unless directed otherwise in Section 8.4. Important information for the advisor: Do not collect premium or release the Temporary Insurance Agreement if the total amount of either life insurance or critical illness insurance applied for exceeds \$1,000,000 per life insured. If applying for a product with preferred underwriting classes, the applicable premium at Standard rates must be submitted for the TIA payment precondition to be met. Other pre-conditions for temporary insurance are described in Section 9.2.

Who will be paying the premiums for every policy applied for?

If other, please specify: Select all that apply: Insured 1 Insured 2 Owner 1 Owner 2 Other

If a premium payor is not an Owner or an Insured under the policy, complete Section 1.5.

Initial premium:

- Issue as COD (collect premiums on delivery), or
- Draw initial premium by pre-authorized debit (PAD), or
- Initial premium submitted by cheque with this application (specify): \$

Policy premium payment frequency and method: Monthly PAD Annual PAD Annual Billing

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

Name / Nom P.O. Box / C.P. 000 City / Ville, Prov AOB 1C2	Cheque No. N° de chèque	001	
Pay to the order of Payez à l'ordre de	Date		
VOID		\$ <input type="text"/>	
		/100 Dollars	
001	00002	003	
000000000123			
Cheque No. N° de chèque	Branch No. N° de la succursale	Institution No. N° de l'institution financière	Bank Account No. N° du compte

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

8.2 Language & mailing address

Issue each policy and future communications: English Français

Send statements and future communications to (specify only one): Owner 1 Owner 2 Third party
Other:

Mailing address (street name and number, apartment number)

City Province Postal code Country

8.3 Issue Instructions

Backdate to save age (up to 6 months from the date of underwriting approval for life insurance or 30 days for critical illness insurance)

Date (mmm/dd/yyyy):

Special dating instructions:

If you are applying for joint coverage and an Insured is declined: Issue coverage on the approved single life (default) Close file

If underwriting decision is less favourable than as applied for: Issue with applied for amount Contact advisor (default)

Concurrent applications on the life of a family member or partner

- Issue my coverage as soon as it is approved (default)
- Hold issue until you approve coverage on the life of:

8.4 Further premium and issue instructions:

8.5 Pre-authorized Debit Plan Agreement ("Agreement")

For purposes of this Agreement: "Insurer" means, as applicable, each of The Independent Order of Foresters and Foresters Life Insurance Company; "Policy" means a certificate or policy issued by an Insurer and includes each rider that is attached to it.

The payor, by signing below, verifies that the payor is an account holder of the account identified on the attached VOID cheque or in Section 8.1 of this Application for Life and Critical Illness Insurance ("Application") and agrees that:

1. The Insurer issuing a Policy 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 Policy issued by that Insurer in response to this Application, such as for additional coverage or loan repayment(s);
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 Policy 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 Policy while that Policy 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 its address and phone number:
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 Policy 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 payor authorizes disclosure of payor and account information for identity verification and record keeping purposes and to administer payments, the policy and benefits.

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

Deductions under this Agreement are: Personal Business related

Signature of account holder

Date (mmm/dd/yyyy)

X

Signature of joint account holder

Date (mmm/dd/yyyy)

X

9.1 Application for temporary insurance

'You' and 'your' in section 9.1 means Insured 1 and Insured 2, individually, identified in section 1.1 and 1.2	Insured 1		Insured 2	
A Are you 66 years of age or over, or less than 15 days old?	Yes	No	Yes	No
B Has an application for insurance on your life ever been rated, declined or modified?	Yes	No	Yes	No
C Have you ever been treated for or had an indication, sign or symptom of cancer, tumour, stroke, heart disease, blood vessel disorder or disease, diabetes, loss of speech, loss of limb, severe burns, deafness, blindness, current or recurring kidney, liver or lung disorder, Alzheimer's, Huntington's or Parkinson's disease, or a disease or disorder of the nervous system?	Yes	No	Yes	No
D Have you ever had or been told you have acquired immune deficiency syndrome (AIDS), positive HIV test, or a disorder or disease of the immune system?	Yes	No	Yes	No
E Within the last 2 years, have you been hospitalized (except for childbirth)?	Yes	No	Yes	No
F Within the last 6 months, has a disorder, disease, injury or illness prevented you from performing your regular activities or caused you to be absent from work for more than 7 consecutive calendar days?	Yes	No	Yes	No
G Are you aware of a symptom, illness or complaint for which you have not yet sought medical advice, or for which treatment or a test is recommended, planned or pending, or testing with results of which you are unaware?	Yes	No	Yes	No

9.2 Pre-conditions for temporary insurance

Subject to the terms of the Temporary Insurance Agreement (TIA), form 106172 CAN, temporary insurance will be provided to an Insured if each of the following pre-conditions is met:

1. That Insured is older than 14 days and younger than 66 years on the date the TIA is signed by the advisor.
2. Each of the questions in Section 9.1 above is answered "no" in relation to that Insured, and the "no" answers are truthful.
3. At least 1/12th of the total annual premium for each policy applied for is provided with this application either by cheque or pre-authorized debit that is honoured on presentation to the financial institution from which it is to be collected. That total annual premium amount must be based on standard rates, even if applying for a policy with preferred underwriting classes.
4. Each Insured and Owner signed the Application.

If a Joint Policy is being applied for, both Insureds must apply and qualify for coverage under the TIA for any coverage under the TIA to come into effect. If a spousal rider is being applied for, Insured 2 (insured under spousal rider) is only eligible to apply and qualify for coverage under the TIA if Insured 1 applies and qualifies for coverage under the TIA. If separate policies are being applied for by Insured 1 and Insured 2, then they can each apply and qualify for coverage under the TIA independently of the other.

If one or more pre-condition is not met, no temporary insurance takes effect for that Insured even if the TIA was left with either an Insured or Owner and/or premium was provided, authorized to be deducted or collected.

10. Agreements & Authorizations

10.1 Agreement

"Application" means this Application for Life and Critical Illness Insurance. "I/me" means individually each person identified in this Application as an insured, owner or the parent/legal guardian signing this Application in relation to a minor child. "Insured" means each person identified as either Insured 1 or Insured 2 in this Application. "Insurer" means each of The Independent Order of Foresters and Foresters Life Insurance Company. "Owner" means each person identified as either Owner 1 or Owner 2 in this Application. "Policy" means a certificate or policy issued by an Insurer and includes each rider that is attached to it.

I, by signing this Application, agree that:

1. The statements and answers contained in this Application, and other evidence of insurability signed or provided by me, including but not limited to the Medical Declaration and Examination Report and any questionnaires, are true and complete and will be relied upon by each Insurer in deciding whether to issue a Policy.
2. A Policy issued, if any, by an Insurer will only come into effect according to the terms of that Policy that may include factors such as the date the application was approved, the Policy Issue Date, payment of the first premium and provided there is no change in insurability as described in the Policy.
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 a Policy.
4. For each Policy issued by The Independent Order of Foresters, its Instruments of Incorporation and Constitution now in force or subsequently amended shall form part of the entire contract.
5. If signing this Application with respect of a child, I confirm that I have full knowledge of the child's medical history sufficient to answer all questions accurately and that I have the authority to consent to the insurance applied for in this Application, and issued, if any, on that child's life.
6. The language of each Policy issued as a result of this Application and all correspondence shall be the same as that of this Application unless otherwise requested in Section 8.2.
7. Temporary insurance, if applicable, is subject to the Temporary Insurance Agreement (TIA) and Receipt included with this application form 106184 CAN, including the pre-conditions regardless of whether a) the TIA was or was not left with the Insured or the Owner, and b) premium was or was not provided, by any method, with this application, or a premium was subsequently collected.
8. I, Owner, have received a copy of the Important Notices page, or if a proposed insured who is not an Owner I have reviewed the Notice Regarding MIB contained on the Important Notices page, however, if this is an electronic application and/or an electronic signature, I, as an Owner or proposed insured, understand that the Important Notices page will instead be available as part of the electronic process.

I further understand and agree that:

- A. Changes or corrections made to this Application, if any, by an Insurer are ratified by each Owner if the Policy delivered to an Insured or 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. Each 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 or mobile number(s), either provided in this Application or number(s) that I later provide.
- D. If I have chosen to provide a current internet e-mail address or other electronic contact information in this Application or choose to provide such address or contact information in the future, the Insurer, its affiliates and subsidiaries may use that address or contact information to send messages, information or documents to me electronically relating, directly or indirectly, to this Application, an Insurer, Policy, membership, event, 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.

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

You can save or print the insurance contract and related documents. The number of pages to print can be as much as or more than 70 pages. A request for a duplicate copy, in paper, may require payment of an administrative fee (currently \$25, subject to change) and it will be mailed to you within a reasonable period of receipt of payment by an Insurer. Payment can be made by cheque payable to Foresters Financial or by online banking.

10.2 Authorization

The following definitions apply for purposes of this Authorization: "Application", "I/me", "Insured", "Insurer", "Owner" and "Policy" have the same meaning as defined in the Agreement subsection of this Application. "Authorized Person" means each Insurer, reinsurer, advisor, each person signing this Application or related form or participating in the Application process, insurance agency, managing general agency and market intermediary related to this Application or a Policy and the respective parent, affiliates, subsidiaries 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, Policy, benefit claim, membership or management of the respective business of each. "Authorized Child" means each person proposed for insurance in this Application who is under age 16 (18 in Quebec) and for whom I am signing this Application as the parent or legal guardian of that person. "Authorized Purpose" means: participating in an insurance application process; assessing or servicing or administering insurance coverage, each Policy, claim or the benefits of membership; identity verification, auditing, data loss analysis, recordkeeping, compliance; tax reporting; informing of the benefits of membership; 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.

Do you, the undersigned, authorize the Insurer, at its discretion, to share the following information with your advisor about you and each Authorized Child if that information affects that Insurer's decision about whether to insure you or an Authorized Child and, if so, on what basis:

- That Insurer's findings about blood pressure, cholesterol level or physical build, and
- Information in this Application, supplementary questionnaire, paramedical interview or other evidence of insurability?

Insured 1		Insured 2		Owner 1		Owner 2	
Yes	No	Yes	No	Yes	No	Yes	No

I, by signing this Application, authorize on my own behalf and on behalf of each Authorized Child, the collection, use and disclosure of information about me and each Authorized Child as follows: For Authorized Purposes by and between Authorized Persons and to or from health professionals, physicians, hospitals, clinics, medically related facilities, employers, government agencies, provincial health care plans and motor vehicle departments, insurance entities, MIB Inc., pharmacies, pharmacy benefit managers, benefit administrators, financial institutions, investigative or consumer reporting agencies, law enforcement agencies, insurers, reinsurers, beneficiaries and claimants; Each Insurer may make a brief report about me and each Authorized Child to MIB, Inc. even if this application is cancelled or withdrawn and provide my medical information to the regular physician identified in section 5 of this Application and each Authorized Child's medical information to the regular physician identified in section 6 of this Application in the event that coverage is rated, restricted, offered or not.

Each person signing this authorization may, by written notice to an Insurer, revoke their authorization in relation to that Insurer. Revoking authorization, however, will not affect action(s) begun before receipt of notice or prevent that Insurer from using personal information to administer a Policy, report to MIB, Inc., or to inform of or administer the benefits of membership.

10.3 I understand and agree that my signature below applies to, and is for the purposes of, this entire Application. The signer must be at least 16 years old, 18 in Quebec.

Signature of Insured 1 X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of Insured 2 X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of Insured Child X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of Insured Child X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of Insured Child X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of Owner 1 X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of Owner 2 X	Signed in Province/Territory	Date (mmm/dd/yyyy)
Signature of parent or legal guardian X	Signed in Province/Territory	Date (mmm/dd/yyyy)

11. Advisor's report

11.1 Advisor information

Advisor's name <i>(this advisor is considered the initial servicing advisor)</i>	Advisor code	Agency code	Split %
Advisor's name	Advisor code	Agency code	Split %
Advisor's name	Advisor code	Agency code	Split %

11.2 MGA Information

MGA name	MGA code	Affix MGA stamp, if applicable
MGA office contact person	Contact phone #	
MGA office contact email		

11.3 Relationship to Insured & disclosure

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-Application

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 an 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 each Insured? Less than 1 month
Month(s)
Year(s)

5. If you are related to an Insured, list the nature of your relationship.

11.4 Requirements ordered

	Insured 1	Insured 2		Insured 1	Insured 2
Vitals			Medical exam		
Urine HIV			Electrocardiogram		
Blood profile			Treadmill ECG		
Paramedical exam			Motor Vehicle Report		
Name of paramedical provider			Order number		
Who should be contacted for an Inspection Report?			Best time to contact?		

11. Advisor's report continued

11.5 Additional comments

11.6 Advisor signature

I provided to the Insured the Important Notices page, however, if this is an electronic Application, the Important Notices will instead be available as part of the electronic 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 each 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 details to compliancecda@foresters.com.

Owner identity has been or will be verified as follows (please specify):

This Application was completed in person. I have reviewed the Owner's original, valid, and unexpired identification document on the date of my signature below (or the following date _____), and the identification details provided in this Application match that identification.

This Application was not completed in person. I have reviewed the Owner's original, valid, and unexpired identification document on the date of my signature below (or the following date _____), and the identification details provided in this Application match that identification.

This Application was not completed in person and the Owner's identification was not verified.

Signature of Advisor

Date (mmm/dd/yyyy)

X

Important 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 you 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 Inc, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. 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 policy 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 Foresters Application for Life and Critical Illness Insurance signed by you. 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. Foresters 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 Foresters Application for Life and Critical Illness Insurance is an independent licensed insurance advisor authorized by the insurer, being either or both of the Foresters Life Insurance Company and/or The Independent Order of Foresters, 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.

Temporary Insurance Agreement and Receipt

Definitions

Insured and Owner mean each person identified as an Insured and/or Owner, respectively, in Section 1 of the Application. Application means the Foresters Application for Life and Critical Illness Insurance signed by, or on behalf of, each Insured and Owner. TIA means this Temporary Insurance Agreement and Receipt. Insurer means each of The Independent Order of Foresters and Foresters Life Insurance Company. Covered Impairment means the definition or description of covered impairment in the applicable critical illness insurance policy applied for in the Application.

Pre-conditions for Temporary Insurance

Subject to the terms of this TIA, temporary insurance will be provided to an Insured if each of the following pre-conditions is met:

1. That Insured is older than 14 days and younger than 66 years on the date this TIA is signed by the advisor.
2. Each of the questions in the Application for temporary insurance section of the Application is answered "no" in relation to that Insured, and the "no" answers shown are truthful.
3. At least 1/12th of the total annual premium for each policy applied for is provided with this Application either by cheque or pre-authorized debit that is honoured on presentation to the financial institution from which it is to be collected. That total annual premium amount must be based on standard rates, even if applying for a Policy with preferred underwriting classes.
4. Each Insured and Owner signed the Application.

If a Joint Policy is being applied for, both Insureds must apply and qualify for coverage under the TIA for any coverage under the TIA to come into effect. If a spousal rider is being applied for, Insured 2 (insured under spousal rider) is only eligible to apply and qualify for coverage under the TIA if Insured 1 applies and qualifies for coverage under the TIA. If separate policies are being applied for by Insured 1 and Insured 2, then they can each apply and qualify for coverage under the TIA independently of the other.

If one or more pre-condition is not met, no temporary insurance takes effect for that Insured even if the TIA was left with either an Insured or Owner and/or premium was provided, authorized to be deducted or collected by us.

When Temporary Insurance Begins and Ends

If each pre-condition is met, temporary insurance under this TIA will be in effect beginning on the date and time the last signature, required of the Insured(s) and Owner(s) in this Application, was applied and will end automatically, and no longer be in effect, on the earliest of the following, as shown in an Insurer's records:

- a. The 90th day from the date this temporary insurance begins;
- b. The date that insurance takes effect under the policy applied for;
- c. The date a policy, other than applied for, is offered by an Insurer;
- d. The date the application is withdrawn, cancelled, suspended or declined, whether orally or in writing;
- e. The later of the date an Insurer sends notice to an Insured or Owner, and the date shown on such notice, terminating this TIA; and
- f. The date the cheque submitted, or pre-authorized debit provided, with the Application is not honoured on presentation.

It is acknowledged that the sum of \$ _____ was provided or authorized when the Application was completed and signed.

Limitations and Exclusions

1. There is no temporary insurance for the death of an Insured if only critical illness insurance is applied for in the Application for that Insured.
2. There is no temporary insurance for a Covered Impairment of an Insured if critical illness insurance is not applied for in the Application for that Insured.
3. This TIA shall be void and each Insurer's liability is limited to the amount of the payment collected by that Insurer in relation to the Application where: (a) There is fraud, material misrepresentation or nondisclosure in the Application or in a document submitted as evidence of insurability such as, but not limited to, a paramedical report or questionnaire; or (b) the death or Covered Impairment results from any of the following: suicide or suicide attempt, respectively; self-inflicted injury; voluntary or involuntary ingestion or administration of a drug, whether prescribed or not; alcohol or an alcohol or drug related condition.
4. There is no temporary insurance for the following Covered Impairments: (a) cancer, (b) brain tumour, or (c) a Covered Impairment that an Insured is first diagnosed with while this TIA is in effect but that Insured does not survive 30 days from the date of that diagnosis.


Entire Agreement

This TIA contains the entire terms regarding temporary insurance. No person, including the advisor, is authorized to waive, amend or modify the terms of this TIA. No coverage will take effect except as stated in this Agreement.

Benefit Payment

Subject to the terms of this TIA:

1. If the Insured dies while this TIA is in effect and that Insured applied for life insurance in the Application, the Insurer that underwrites that life insurance applied for shall pay in the aggregate, under this TIA and all other temporary insurance in effect for that Insured with that Insurer as of that Insured's date of death, the lesser of \$1,000,000 and the amount of that life insurance applied for in the Application. However, in the case of Joint First-to-die coverage, that amount will only be payable on the death of the first Insured to die. In the case of Joint Last-to-die coverage, that amount will only be payable on the death of the last Insured to die. That amount payable shall be paid according to the beneficiary designation(s) in the Application.
2. If the Insured is first diagnosed with a Covered Impairment while this TIA is in effect and that Insured applied for critical illness insurance in the Application, the Insurer that underwrites that critical illness insurance shall pay in the aggregate, under this TIA and all other temporary insurance in effect for that Insured with that Insurer as of the date first diagnosed, the lesser of \$500,000 and the amount of that critical illness insurance applied for in the Application. That amount payable shall be paid in equal shares to each Owner.

Advisor name	Signature of Advisor	Date (mm/dd/yyyy)
		

e-SIGNATURE AND e-DELIVERY CONSENT

CONSENT TO USE OF ELECTRONIC SIGNATURES AND RECEIPT OF DISCLOSURES EXCLUSIVELY THROUGH ELECTRONIC MEANS

Thank you for using the electronic application process that involves electronic signatures, electronic records and electronic delivery of documents. In this Consent: "You" means each Owner applying for insurance, each person proposed as an Insured, Parent/Legal Guardian and/or the Payor authorizing recurring bank debits.

Electronic Signatures – By electronically signing each applicable document you are agreeing to using electronic signatures to sign, and initial as applicable, the Application for Insurance and each related document that has a signature line for you as either the Insured, Owner and/or Payor.

Electronic Document Delivery – By accessing the documents electronically you agree that documents related to the application for insurance and/or the product(s) applied for will be available to you electronically.

The Advisor who assisted with this application cannot create or provide you with an email address to use for either applying your electronic signature or to receive documents electronically.

Confirmation of Pre-Authorized Debit (PAD) Sign-up

If you are the payor, thanks for authorizing Pre-Authorized Debits by either The Independent Order of Foresters and/or Foresters Life Insurance Company as applicable based on the product(s) applied for ("Foresters")

Your PAD agreement will be accepted if and when we agree to issue the certificate to which your PAD agreement applies. Receiving this confirmation does not mean there is insurance coverage with Foresters. The details of your PAD agreement, including: (a) the name of the financial institution; (b) the transit, bank and account number; (c) the type of account and (d) the frequency of payment are each included in the Application for life and critical illness insurance (the "Application").

Please note that the expected PAD payment amount may have been provided to you by your insurance advisor, however the actual amount will not be confirmed until a certificate has been issued. The start date for your PAD agreement will be at or following the issue date of the applicable certificate.

You have waived your right to receive pre-notification of the amount of the PAD and agreed that you do not require advance notice of the amount of PADs before the debit is processed.

Your PAD Agreement may be cancelled provided notice is received 30 days before the next scheduled PAD. If any of the details included in the Application are incorrect, please contact your advisor immediately. If the details are correct, you do not need to do anything further and your Pre-Authorized Debits will be processed as stated above.

You have certain recourse rights if any debit does not comply with these terms. For example, you have the right to receive a reimbursement for any PAD that is not authorized or is not consistent with your application or PAD Agreement. To obtain more information on your recourse rights, contact Foresters at 800-267-8777 or visit www.payments.ca.

Thank you,

Foresters Financial

Foresters Financial

The Independent Order of Foresters
Foresters Life Insurance Company
789 Don Mills Road, Toronto, ON, Canada M3C 1T9
800 828 1540

Foresters Financial and Foresters are trade names and trademarks of The Independent Order of Foresters (a fraternal benefit society, 789 Don Mills Road, Toronto, Ontario, Canada M3C 1T9) and its subsidiaries.