Final Expense Sample Application

This is a sample application, not a promise to issue coverage.

Important Notes:

You **cannot** buy this policy directly from Foresters Financial.

This policy is **sold only via licensed Foresters Financial agencies** such as Choice Mutual.

The Independent Order of Foresters ("Foresters")
A Fraternal Benefit Society.
789 Don Mills Road, Toronto, ON, Canada M3C 1T9 F. 877 329 4631
U.S. Mailing Address: P.O. Box 179 Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Application for Individual Life Insurance

SAMPLE
FROM CHOICE MUTUAL

1. Proposed Insured (full legal name)

First name	Middle name	Last name	○ Male ○ Female
Street address	City	State	Zip
Social security #	Home phone #	Alternate phone/Cell #	Date of birth (mmm/dd/yyyy)	State & Country of birth

U.S. Citizen? ○ Yes ○ No. If "No" then immigration status: ○ Permanent Resident (Green Card) ○ Other (provide visa type): ____________

Type of photo I.D. used to verify identity: ○ Driver's license ○ Passport ○ Other government I.D.: ______________________________

Foresters member? ○ Yes ○ No, applying for membership. | E-mail

Height (ft/in) / Weight (lbs) / | Within the past 12 months, has the Proposed Insured used tobacco or nicotine in any form? ○ Yes ○ No

2. Medical Questions

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

If a "Yes" answer to questions 1-6, the proposed insured is not eligible for Foresters PlanRight. Do not complete or submit this application.

1. Are you:
   a) A resident in, or have you been advised to move into, a nursing home or skilled nursing facility? ○ Yes ○ No
   b) Receiving, or have you been advised to receive, skilled nursing care, hospice care, or home healthcare? ○ Yes ○ No
   c) A patient in a hospital or psychiatric facility, or confined to a correctional facility? ○ Yes ○ No
   d) Using a wheelchair or electric scooter due to an ongoing diagnosed illness, medical condition, or disease? ○ Yes ○ No
   e) Requiring help (from anyone) with administering or taking your medications, or with bathing, dressing, eating, or toileting? ○ Yes ○ No
2. Within the past year (12 months), have you been advised to:
   a) Use, or have you used, oxygen equipment to assist with breathing (excluding use for sleep apnea)? ○ Yes ○ No
   b) Have, or have you had, kidney dialysis? ○ Yes ○ No
   c) Have surgery, a medical procedure, hospitalization, or have you been referred for a check up or consultation with a doctor or medical specialist, which has not yet been started, completed, or for which results are not known? ○ Yes ○ No
   d) Have a diagnostic test, or have you been referred to get a lab test, which has not yet been started, completed, or for which results are not known (excluding tests related to the Human Immunodeficiency Virus (HIV))? ○ Yes ○ No
3. Within the past year (12 months), have you consulted a physician for, been diagnosed with, or received or been advised to receive treatment or medication for, unexplained weight loss greater than 10 pounds? ○ Yes ○ No
4. Have you ever received, or been advised to receive, an organ or bone marrow transplant, or had an amputation that you were advised was due to complications of diabetes? ○ Yes ○ No
5. Have you ever been diagnosed with, or received or been advised to receive treatment or medication for:
   a) Cardiomyopathy, Congestive Heart Failure (CHF), Pulmonary Hypertension, or any other type of heart failure or heart muscle disease? ○ Yes ○ No
   b) Amyotrophic Lateral Sclerosis (ALS), or a terminal illness or end-stage disease? ○ Yes ○ No
   c) Alzheimer's disease, dementia, or memory loss? ○ Yes ○ No
   d) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for HIV? ○ Yes ○ No
6. Have you ever been diagnosed with more than one occurrence of the same or different type of cancer, or do you currently have cancer (the term "cancer" excludes basal cell skin cancer)? ○ Yes ○ No

If all "No" answers to questions 1-6, then continue with questions 7-12.

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Complete questions 7-12 and indicate (e.g. circle or underline) the condition(s) to which each "Yes" answer, if any, applies.

7. Have you ever been diagnosed with diabetes and have also been diagnosed with, or advised to receive treatment for:
   a) Retinopathy (problems with your eyesight)? ○ Yes ○ No
   b) Nephropathy (kidney disease or kidney damage)? ○ Yes ○ No
   c) Peripheral Neuropathy (nerve damage or numbness)? ○ Yes ○ No
8. Within the past 2 years (24 months), have you been hospitalized for 48 hours or more that you were advised was due to diabetes? ○ Yes ○ No
9. Within the past 2 years (24 months), have you been diagnosed with, or received or been advised to receive treatment for:
   a) Alcohol or drug abuse, or have you used illegal drugs? ○ Yes ○ No
   b) An aneurysm, or have you ever been diagnosed with an aneurysm that has not yet been repaired? ○ Yes ○ No
   c) A brain tumor, or have you ever been diagnosed with a brain tumor that has not yet been treated or is being monitored or observed? ○ Yes ○ No
10. Within the past year (12 months), have you been diagnosed with having:
   a) A heart attack, stroke, or Transient Ischemic Attack (TIA/mini-stroke)? ○ Yes ○ No
   b) Angina, or have you taken medication for angina? ○ Yes ○ No
11. Within the past year (12 months), have you been advised to have, or have you had, a pacemaker or defibrillator implant, cardioversion treatment, or any other type of heart or circulatory procedure? ○ Yes ○ No
12. Within the past 3 years (36 months), have you been diagnosed with cancer, or received or been advised to receive chemotherapy, radiation, or any other type of treatment for cancer (the term "cancer" excludes basal cell skin cancer)? ○ Yes ○ No

If a "Yes" answer in questions 7-12, then apply for Foresters PlanRight (Basic). If all "No" answers then continue with questions 13-15.

Complete questions 13-15 and indicate (e.g. circle or underline) the condition(s) to which each "Yes" answer, if any, applies.

13. Have you ever been diagnosed with, or received or been advised to receive treatment or medication for:
   a) Parkinson's disease or Systemic Lupus (SLE)? ○ Yes ○ No
   b) Hepatitis B or C, cirrhosis of the liver, or any other type of liver disease or condition? ○ Yes ○ No
   c) Chronic kidney disease, chronic renal insufficiency, or any other type of kidney disease or condition (excluding kidney stones)? ○ Yes ○ No
   d) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, or any other type of chronic lung disease or ongoing respiratory condition (excluding asthma or sleep apnea)? ○ Yes ○ No
14. Within the past 2 years (24 months), have you been diagnosed with having:
   a) A heart attack, stroke, or Transient Ischemic Attack (TIA/mini-stroke)? ○ Yes ○ No
   b) Angina, or have you taken medication for angina? ○ Yes ○ No
15. Within the past 2 years (24 months), have you been advised to have, or have you had, a pacemaker or defibrillator implant, cardioversion treatment, or any other type of heart or circulatory procedure? ○ Yes ○ No

If a "Yes" answer in questions 13-15, then apply for Foresters PlanRight (Standard).
If all medical questions 1-15 are answered "No", then apply for Foresters PlanRight (Preferred).

3. Insurance Applied For

Certificate type (based on answers to Section 2 Medical Questions)

If there is a "Yes" answer to questions 1-6, do not complete or submit this application.

If there is a "Yes" answer to questions 7-12, then you are applying for Foresters PlanRight: ○ Basic (graded death benefit)

If there is a "Yes" answer to questions 13-15, then you are applying for Foresters PlanRight: ○ Standard (level death benefit)

If all medical questions are answered "No" then you are applying for Foresters PlanRight: ○ Preferred (level death benefit)

Insurance amount: $ ____________

Additional coverage: (only available if applying for Foresters PlanRight (Preferred)
○ Accidental Death Rider $____________ (benefit amount)

Premium amount: $ ____________ (based on payment mode, including premium for Accidental Death Rider, if applied for)

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

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4. Automatic Premium Loan

Automatic premium loan provision elected? ○ Yes ○ No

If "Yes", overdue premium will be paid through a loan against, and for as long as there is, available cash value, if any.

If "No", or if an election is not made, the certificate's Nonforfeiture provisions will automatically apply, if premium is overdue at the end of the Grace Period.

5. Payment Information

Payer is: ○ Proposed insured ○ Owner (if other than proposed insured) ○ Other (Complete Contingent Owner/Other Payer I.D. Form)

First premium payment provided by: ○ Pre-Authorized Check (PAC) ○ Check

Subsequent premium payments made by: ○ Pre-Authorized Check (PAC) ○ Direct bill

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

Requesting a specific draft day?

○ No (draft first premium payment immediately upon Foresters application approval)

○ Yes (choose option below)

○ Draft on the _____ day (choose between 1st and 28th) of the month.

○ Draft on the _____ (choose 1st to 4th) ______________ (choose Monday to Friday) of the month

For PAC, I understand premiums will be drafted on the day I requested, with the exception of the initial premium which may occur on a day other than specified on this application. If no day was requested, the premium will be drafted in accordance with the certificate issue date.

PAC Banking information to be taken from:

○ Void check (attach here) ○ Information completed below (if no check available) ○ Check submitted with the application

Type of Account: ○ Checking ○ Savings

Name of financial institution: ______________________________

Routing Transit # (9 digits): ______________________________

Account # (maximum 17 digits): ______________________________

PAC Authorization

The payer, by signing below, verifies that the payer is the account holder of the account identified in the PAC banking information section (above) and is permitted to provide this authorization, and agrees that: 1) Foresters is authorized to electronically draft deductions, for premiums and/or other payments related to an insurance contract issued, if any, as a result of this application, from that account or another account later identified or substituted by, or on behalf of, the payer, such as for additional coverage, loan repayment(s) or for premium deposit funds. 2) The financial institution from which deductions are to be drafted is authorized to treat each draft by Foresters as though it was made personally by the payer. 3) Foresters reserves the right to determine when the first deduction and each subsequent deduction, if any, will be made and the amount of each deduction. Subsequent deduction amounts may vary. 4) If a deduction request is not honored when submitted to the financial institution Foresters may, at its sole discretion, do further resubmits for the deduction. 5) This authorization is effective immediately and will continue until terminated, which either the payer or Foresters may do at any time by written notice to the other.

This authorization must be signed by the account holder as his/her name appears on banking records for the account provided. If the account provided is a joint account that requires two signatures, then both account holders must sign.

______________________________ **x** ______________________________

Print Name of Payer / Print Name of joint account holder (if required) | Signature of Payer / Signature of joint account holder (if required)

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

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6. Other Insurance and Financial Questions

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

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

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

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

Full legal name of Individual (First, Middle, Last), Institution, or Trust			Social security/Tax ID #	
Street address		City	State	Zip
Type of photo I.D. used to verify identity: ○ Driver's license ○ Passport ○ Other government I.D.: ___				
Relationship to proposed insured		E-mail	Phone #	
If Trust:	Name of Trustee	Date of Trust agreement		
If Individual:	○ Male ○ Female	Date of birth (mmm/dd/yyyy):	U.S. Citizen? ○ Yes ○ No. If "No" then immigration status: ○ Permanent Resident (Green Card) ○ Other (provide visa type): ___	

8. Secondary Addressee (Optional. To designate another person to receive notification of a possible lapse in coverage.)

Name (First, Middle, Last)			○ Male ○ Female
Street address	City	State	Zip

9. Beneficiary Information (Each beneficiary below is revocable, unless "irrevocable" is written next to the name of that beneficiary.)

Primary	Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	% Share
Name: Address:			The
Name: Address:			total
Name: Address:			must
Name: Address:			equal
Name: Address:			100%
Contingent	**Date of birth (mmm/dd/yyyy)**	**Relationship to proposed insured**	**% Share**
Name: Address:			The total
Name: Address:			must equal
Name: Address:			100%

10. Additional Information

Is the proposed insured taking dual use medication? ○ Yes ○ No

If "Yes", list each dual use medication and the reason it was prescribed: ___

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11. Agreements

I, the proposed insured and/or owner, declare that I have reviewed all of the statements and answers as they pertain to me and that they are true and complete to the best of my knowledge and belief. The statements and answers in this application are the basis for an insurance contract (defined as a certificate and each rider attached to that certificate), if any, issued by Foresters. No information about me will be considered to have been given to Foresters by me unless it is stated in this application. A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. No producer, medical examiner, or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to make, modify, or discharge an insurance contract. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. Foresters will have no liability under an insurance contract issued based on this application until the date that insurance contract comes into effect, according to its terms and then only if the first premium due is provided in full on or before the delivery date of that insurance contract, and provided that there has been no change in either an answer to an application question or the proposed insured's health or habits between the date this application was signed and the issue date of that insurance contract. Changes or corrections made to this application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. This application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently enacted, shall form part of the entire contract with Foresters. This application and related documents may be sent by electronic means. Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this application or number(s) that I later provide. If I have chosen to provide an email address in this application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. Foresters may review, transfer and otherwise use, information provided in this application to offer and issue (including post issue administration), other insurance products to me. Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identification. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. If I am the owner and if the life insurance applied for has a level death benefit, I have been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

12. Authorization To Obtain And Disclose Information

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

13. Signature Section (For purposes of sections 1 to 12. Review entire Application before signing.)

X ______________________________
Proposed Insured's signature

X ______________________________
Owner's signature (if other than the Proposed Insured)

The owner, or the proposed insured, if the proposed insured is the owner, signed in: __________ on: __________________
State / Date (mmm/dd/yyyy)

14. Producer Certification

I certify the following: I am not aware of undisclosed information about the health, habits, or lifestyle of the proposed insured that might affect insurability. I complied with applicable regulatory requirements including those relating to the solicitation and sale of life insurance to active duty members of the United States military. All questions, to which an answer is shown, were asked as written in this application. The answers given by the proposed insured or owner were recorded as shown and this application was reviewed with the proposed insured and owner before it was signed. If the life insurance applied for has a level death benefit, the owner has been provided, either in paper or electronically, with the Accelerated Death Benefit Disclosure.

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

Producer's full name: ______________________________

Producer's signature: X ______________________________

Producer number: ______________________________

Date (mmm/dd/yyyy): ______________________________

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