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

Foresters Financial

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

Proposed Insured

First name: JOHN Middle name: DOUG Last name: DOE

Strong Foundation Term Life

Amount of life insurance applied for on the proposed insured: $ 100,000

Simplified Issue	Fully Underwritten
Term: ○ 15 year ⊗ 20 year ○ 25 year ○ 30 year	Term: ○ 10 year ○ 15 year ○ 20 year ○ 25 year ○ 30 year

Riders (Subject to state and product availability.)

○ Accidental death: $ _____	○ Children's term: $ _____	
○ Critical illness (accelerated death benefit): $ _____	○ Disability income (accident only): $ _____	○ Waiver of premium
○ Other rider(s): _____		

Remarks:
MONTHLY PREMIUM: $102.90

There may be additional Disclosure forms required. Check the State requirements as these forms would need to be completed before the certificate can be issued.

This form is part of the Application for Individual Life Insurance.

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Foresters Financial

Application for Individual Life Insurance

Proposed Insured

First name	Middle name	Last name	
JOHN	DOUG	DOE	☒ Male ○ Female

Street address	City	State	Zip
895 HERR STREET	ENGLEWOOD	OH	45322

Social security #	Home phone #	Alternate phone/Cell #	Date of birth (mmm/dd/yyyy)	State & Country of birth
222-22-2222	(937)832-1378	—	11-22-1960	OH USA

U.S. citizen? ☒ Yes ○ No. If "No", immigration status: ○ Green card holder ○ Permanent resident ○ Other (provide Visa type):

Type of Photo I.D.: ☒ Driver's license State: OH ○ Passport ○ Other government I.D.:

Photo I.D. # (used to verify identity): RW 111111

Occupation & duties: ELECTRICIAN

☒ Full time ○ Part time ○ Seasonal | Income (past 12 months): $ 60,000 | Active duty military or reserves? ○ Yes ☒ No

Foresters member? ○ Yes ☒ No, applying for membership. | Email: — | Primary language: ☒ English ○ Spanish

Owner (Complete only if other than the proposed insured. If there is to be a contingent owner, use the Contingent Owner/Other Payer I.D. Form.)

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust			Social security # / Tax I.D. #

Street address	City	State	Zip

Type of Photo I.D.: ○ Driver's license State: ○ Passport ○ Other government I.D.:

Photo I.D. # (used to verify identity):

Relationship to the proposed insured: | Email:

Phone #	If Trust, name of Trustee	If Trust, date of Trust agreement

If Individual: ○ Male ○ Female | Date of birth (mmm/dd/yyyy) | U.S. citizen? ○ Yes ○ No. If "No", immigration status: ○ Green card holder ○ Permanent resident ○ Other (provide Visa type):

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

	Date of birth (mmm/dd/yyyy)	Relationship to proposed insured	% Share
Primary			
Name: MARY A DOE Address: SAME AS INSURED	12-25-1960	WIFE	100%
Name: Address:			must equal
Name: Address:			100%
Contingent			
Name: Address:			Total must
Name: Address:			equal 100%

Financial Questions

1. Is there an understanding or agreement, whether in writing or not, or has an offer been made to:
   a) Borrow or be given money, or other property, to pay for or enter into the insurance contract applied for? ○ Yes ☒ No
   b) Sell, transfer or assign an insurance contract issued as a result of this Application? ○ Yes ☒ No
   If "Yes" to 1a or 1b, provide details.

For each "Yes" answer to a question in the Lifestyle, either Medical, a Rider or the Other Insurance section, providing details in the Additional Information section or completing the corresponding questionnaire may be required. For purposes of these questions, "you" and "your" mean the proposed insured, "diagnosed", "tested", "advised", "treated", "counseling" and "treatment" mean by a licensed physician or medical practitioner.

Lifestyle Questions	
2. Within the past 12 months, have you used tobacco, in any form, or another nicotine product? If "Yes", specify: ○ Cigarettes ○ Other	○ Yes ⊗ No
3. Within the past 5 years, have you: a) Used marijuana (more than once a week), heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or another controlled substance except as prescribed by a licensed physician or medical practitioner? b) Received or been advised to receive treatment or counseling for, or to discontinue or reduce, the use of alcohol, or a non-prescribed or prescribed drug?	○ Yes ⊗ No ○ Yes ⊗ No
4. Do you expect, within the next 2 years, to change your country of residence or to travel outside of the United States, Canada, Caribbean Islands (excluding Haiti), Western Europe, Hong Kong, Australia or New Zealand?	○ Yes ⊗ No
5. Within the past 2 years, have you: a) Flown, or do you intend within the next 2 years to fly, in an aircraft as a student pilot or licensed pilot? b) Engaged, or do you intend within the next 2 years to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?	○ Yes ⊗ No ○ Yes ⊗ No
6. Within the past 5 years, have you had your driver's license suspended or revoked or been convicted of or pled guilty to more than 3 moving violations or to 1 or more driving while impaired or under the influence violations?	○ Yes ⊗ No
7. a) Within the past 10 years, have you been convicted of or pled guilty to a felony? b) Are you currently on parole, incarcerated, or serving probation or within the past 12 months have you served probation?	○ Yes ⊗ No ○ Yes ⊗ No

PART 1: Medical Questions	
8. Your: Height (ft/in): 5'10" Weight (lbs): 220	
9. a) Date you last consulted a physician: 4-2016 Physician Name: DR. JONES Address: 12 W. WENGER RD, ENGLEWOOD, OH Phone #(555)555-5555 b) Reason(s) you last consulted a physician: ANNUAL CHECK-UP 45322 c) Were you advised that results of that consultation were outside normal ranges?	○ Yes ⊗ No
10. Are you currently taking prescription medication or under treatment?	○ Yes ⊗ No
11. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	○ Yes ⊗ No
12. Within the past 2 years, have you: a) Had or been advised to have a test (other than for HIV) such as an EKG, CT scan, bone scan, MRI scan, colonoscopy, echocardiogram, angiogram, biopsy, or endoscopy? b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known?	○ Yes ⊗ No ○ Yes ⊗ No
13. Do you currently: a) Reside in a nursing home or skilled nursing facility or psychiatric facility, or are you receiving or been advised to receive, skilled nursing care, hospice care, or home healthcare for a terminal condition that is expected to result in death within the next 12 months or for a chronic condition? b) Require the use of a wheelchair due to a chronic illness or disease? c) Require assistance with any of the following activities of daily living: taking medications, bathing, dressing, eating, or toileting?	○ Yes ⊗ No ○ Yes ⊗ No ○ Yes ⊗ No
14. Within the past 3 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for sleep apnea, seizures or epilepsy?	○ Yes ⊗ No
15. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for: a) Diabetes, high blood pressure, a disease or disorder of the blood or lymphatic system, coronary artery disease, heart murmur, chest pain, irregular heartbeat, aneurysm, stroke, transient ischemic attack, congestive heart failure (CHF), a disease or disorder of the arteries or valves, peripheral vascular or arterial disease (PVD or PAD), or had a heart attack, heart surgery, heart procedure or circulatory surgery? b) Cancer (excluding skin cancer that is basal cell carcinoma), tumor, gastrointestinal bleeding, unexplained weight loss, or a disease or disorder of the pancreas or endocrine system? c) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, or a disease or disorder of the respiratory system or do you currently require the use of oxygen equipment? d) Dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, Lou Gehrig's disease (ALS), muscular dystrophy, fibromyalgia, or a disease or disorder of the brain or nervous system? e) Anxiety, depression, manic depression, bi-polar disorder, schizophrenia or a mental health disorder? f) Blood in the urine, hepatitis, Crohn's disease, Systemic Lupus, cirrhosis, or a disease or disorder of the liver, prostate, bladder, kidney, genito-urinary organs, connective tissue or the digestive or immune system (other than HIV)?	○ Yes ⊗ No ○ Yes ⊗ No ○ Yes ⊗ No ○ Yes ⊗ No ○ Yes ⊗ No ○ Yes ⊗ No

PART 2: Additional Medical Questions (Complete only if applying for a medically underwritten product.)

16. Have you ever used tobacco, in any form, or another nicotine product? ○ Yes ⊗ No
If "Yes", specify: Type used: _____ Date last used: _____
If currently smoking, how many pack(s) per day? _____

17. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____ ○ Yes ⊗ No

18. Within the past 5 years, have you consulted a physician other than identified in question 9, or a medical practitioner, or been treated, tested or monitored in a clinic, hospital or emergency room? ○ Yes ⊗ No

19. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for high cholesterol? ○ Yes ⊗ No

20. Net worth: $ 150,000

21. Primary Physician Name (if different from question 9): _____
Address: _____ Phone #: _____

22. Do you have, alive or deceased, a parent or sibling diagnosed with or treated for, prior to age 65, diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, or Alzheimer's? ○ Yes ⊗ No

Details to "Yes"	Age, if living	Age, at death	Details of condition / Cause of death
Father			
Mother			
Sibling(s)			

Disability Income / Waiver Rider Questions (Complete only if applying for disability income or waiver coverage.)

23. a) Hours worked per week (past 6 months): 40+ b) # of weeks worked (past 12 months): 50

24. Within the past 180 days, have you been unable to work at your regular job for more than 20 consecutive days or are you currently not actively at work due to an injury or sickness? ○ Yes ⊗ No

25. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for arthritis or for a disease or disorder of the back, neck or musculoskeletal system? ○ Yes ⊗ No

Children's Term Rider Questions (Complete only if applying for children's term coverage.)

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

26. Within the past 5 years, has a child listed above:
a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disease or disorder? ○ Yes ○ No
b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known? ○ Yes ○ No
If "Yes", to either question 26a or 26b, complete the chart below.

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

Additional Information (Explain all "Yes" answers where applicable.)

Include Question #, diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone #s.

Guaranty Association Notice

FORESTERS™ IS A FRATERNAL BENEFIT SOCIETY LICENSED TO DO BUSINESS IN THIS STATE. AS MEMBERSHIP ORGANIZATIONS, FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN THE STATE GUARANTY ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, CERTIFICATE HOLDERS MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN CERTIFICATES ISSUED BY THE SOCIETY.

Other Insurance (Complete required State and Foresters Replacement/Rollover/Surrender/Disclosure forms. Some states require replacement forms to be completed even if existing insurance is to be kept in force.)

27. Is there another annuity or life insurance application pending, on the life of the proposed insured, with Foresters or another insurer? ○ Yes ☒ No

28. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force? ☒ Yes ○ No

If "Yes", to either question 27 or 28, complete the chart below. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those lapsed or surrendered within the past 13 months.

Name of Insurer	Annuity/Life insurance $	Accidental death $	Critical illness $	Disability income (per month) $	Issue year or indicate if pending
STATE FARM	100,000	—	—	—	2005

29. Have you ever had an application for life, health, disability or critical illness insurance declined, rated or modified? ○ Yes ☒ No
If "Yes", provide date: _____ and reason: _____

30. Will coverage be discontinued or reduced, or premium payments stopped, on existing life insurance coverage or an annuity, if the insurance applied for in this Application is issued (includes military group life insurance)? ○ Yes ☒ No

Payment Information and Authorization (The planned premium quoted may change following underwriting review.)

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

Payment mode: ☒ Monthly (not available for direct bill) ○ Quarterly ○ Semi-annually ○ Annually

First premium payment to be made by: ☒ Pre-Authorized Check (PAC) ○ Check (payable to Foresters) ○ Other

Subsequent premium payments to be made by: ☒ Pre-Authorized Check (PAC) ○ Direct Bill ○ Other

Preferred draft date: ☒ No ○ Yes, draft on the _____ day (between 1st and 28th) of the month.

PAC banking information (including drafting first premium) to be taken from:

☒ Attached void check ○ Check submitted with this Application ○ Information completed below (if no check available)

Type of account: ☒ Checking ○ Savings

Name of financial institution: WRIGHT PATT CREDIT UNION

Routing Transit #: 242279408 Account #: 190000

PAC Authorization

The payer, by signing below, verifies that the payer is the account holder of the account identified in the PAC banking information section (above) and is permitted to provide this authorization, and agrees that: 1) Foresters is authorized to draft deductions, 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. 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 bank account owner as his/her name appears on bank records for the account provided.

X John D. Doe
(Signature of payer)

Conversion Notification

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

John Doe

56-7940/2422

1016

DATE

PAY TO
THE ORDER OF

$

DOLLARS

VOID

Wright-Patt
CREDIT UNION, INC
Fairborn, Ohio 45324-6219
Save Better. Borrow Smarter. Learn A Lot!

MEMO

⑆242279408⑆ 190000 ⑈1016

Temporary Life Insurance Agreement (TIA) Questions & Acknowledgement

Has the proposed insured:

1. Within the past 24 months, had either an investigation or treatment, by a physician or medical practitioner, for chest pain, heart problem, stroke, cancer or AIDS ("Investigation" does not include negative tests for HIV)?	○ Yes ☒ No
2. Within the past 4 months, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)?	○ Yes ☒ No
3. Within the past 4 months, had surgery performed or recommended, had or been medically advised to have a medical test (other than for HIV) or investigation, that has not yet been started or completed, or the results of which are not yet known?	○ Yes ☒ No

TIA Acknowledgement: Were all of the pre-conditions to temporary coverage met?

○ No (Do not provide a check for first premium payment). The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided, authorized or collected. X _____ (Owner's initials)

☒ Yes. I, the owner, understand that temporary coverage is subject to, and I had the opportunity to review, the Temporary Life Insurance Agreement. First premium payment, in the amount of $ 102.90 , is authorized, provided or collected by (select same method chosen in the Payment Information and Authorization section):

☒ Pre-Authorized Check (PAC) ○ Check ○ Other (cannot be a transfer of funds from existing life insurance or annuity contract(s))

Although the first premium payment amount shown above is subject to change following underwriting, this amount must be at least equal to the monthly premium quoted for the insurance, including each rider, applied for in this Application.

Secondary Addressee (Complete only if designating another person to receive notification regarding a possible lapse in coverage.)

First name	Middle name	Last name	○ Male ○ Female
Street address		City / State / Zip	

Declarations and Agreements

"Application" means this Application for Individual Life Insurance and includes additional forms, if any, that are part of this Application. "I/Me" means individually each person identified in this Application as either the proposed insured or the owner, and the parent/legal guardian signing this Application if the proposed insured is a juvenile.

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true, to the best of my knowledge and belief. 4) If I am the owner and if the amount of life insurance applied for on the life of the proposed insured is at least $20,000, I have been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

I understand and agree that: 1) All statements made in this Application shall be representations and not warranties. 2) This Application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently amended shall form part of the entire contract if an insurance contract is issued by Foresters. 3) No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. 6) Foresters will have no liability under an insurance contract issued, if any, as a result of this Application until the date that insurance contract comes into effect, according to its terms, and then only if (a) the first premium due, for that insurance contract, is provided in full on or before the delivery date of that insurance contract and is received by Foresters from the financial institution from which it is to be collected, and (b) between the date this Application was signed and the date that insurance contract comes into effect there is no event, no diagnosed change in health, and no change in the habits or circumstances of the proposed insured, or a child if any, identified in this Application, that would require a change to an answer to a question in this Application. 7) Foresters and its subsidiaries may review, transfer and otherwise use, information provided in this Application or obtained by Foresters or its subsidiaries to assess, develop, or offer and issue to me (including post issue administration), other financial products or benefits. 8) Before issuing an insurance contract, Foresters may require and obtain information about me to validate my identity.

I further understand and agree that: 1) Changes or corrections made to this Application by Foresters, if any, are ratified by the owner if the insurance contract delivered, if any, is not returned during the cancellation period. Such changes or corrections may be made directly on this Application or by an amendment to this Application. 2) No producer, medical examiner or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to make, modify, or discharge an insurance contract. 3) This Application and related documents may be completed, signed and/or submitted to Foresters by voice and/or electronic means and if completed in paper form this original Application may be destroyed after confirmation of successful transmission. 4) Foresters may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 5) I understand that providing an email address is optional. If I have chosen to provide an email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 6) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims, (c) supporting The Independent Order of Foresters ("Foresters") business analysis and operations and (d) record keeping and future servicing by authorized persons. In this authorization, "proposed insured", "owner" and "parent/legal guardian" mean each person identified as such in this Application. "Child" means each child named, if any, and proposed for insurance, in this Application. "Authorized persons" means reinsurers, insurance agents, agencies, and Foresters subsidiaries and those performing services in relation to an application for insurance, insurance product, benefit claim or supporting Foresters business analysis and operations. As evidenced by the signature(s) in the Signature Section of this Application, the proposed insured and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or MIB, Inc. ("MIB"). This includes obtaining records or other information available as to: past, current or future diagnosis, treatment and prognosis of a physical or mental condition; past, current or future drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. Information may be disclosed: between and among Foresters and authorized persons; to companies to which the proposed insured has or may apply to for insurance coverage or benefits; as required or permitted by law. The proposed insured, and owner, on their behalf and on behalf of each child, or the parent/legal guardian on behalf of the proposed insured if the proposed insured is a juvenile, authorizes Foresters and authorized persons, to make a brief report of the proposed insured's and each child's personal and/or protected health information to MIB, even if this Application is cancelled or withdrawn. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization is valid for two years from the date of this Application. 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. Each person signing this authorization may at any time, by written notice to Foresters, revoke their authorization, except that reporting to MIB and action(s) begun before receipt of notice will not be affected. A Notices page has been provided to the proposed insured if this Application was signed in paper or will be sent electronically as part of the signed application package if this Application was signed electronically. It includes the MIB and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

Signature Section (For purposes of entire Application.)

Proposed insured's signature: X John D. Doe
(If the proposed insured is not a juvenile.)

Owner's signature: X
(If other than proposed insured.)

The owner or the proposed insured, if the proposed insured is the owner, signed in OH (State) on 3-17-2016 (mmm/dd/yyyy)

Parent/Legal guardian's name (print full name):
(If the proposed insured is a juvenile and the owner is not a parent/legal guardian.)

Parent/Legal guardian's signature: X

Producer Certification

Unless specifically stated otherwise in the Producer Report, I certify each of the following:

a) I am not aware of undisclosed information about the health, habits or lifestyle of the proposed insured or a child, identified in this Application, that might affect insurability. b) I asked the proposed insured, the parent/legal guardian if the proposed insured is a juvenile, and/or the owner each question as written in this Application to which an answer is shown, and recorded the answers as given to me by each person. c) This Application was reviewed by each person signing in the Signature Section before it was signed by that person. d) This Application has not been altered in any way after the proposed insured, the parent/legal guardian if the proposed insured is a juvenile, and owner signed it. e) 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. f) If applicable, I have disclosed that this Application, if completed in paper form, may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission. g) I have made no misrepresentation(s) about Foresters product(s) applied for in this Application. I have made no promise(s) regarding the benefit(s) or future performance of the product(s) applied for, other than as specifically written in the specific product(s) applied for in this Application. h) If the amount of life insurance applied for on the life of the proposed insured is at least $20,000, the owner has been provided, either in paper or electronically, with the Accelerated Death Benefit Rider Disclosure.

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

Are you related to the proposed insured? ○ Yes ⊗ No

Did you personally meet with the proposed insured and owner and review the document(s) used to verify identity and birth date of each person? ⊗ Yes ○ No

Producer's name (print full name): CODY MICHAEL BECK Producer #: 777777

Producer's signature: X Cody M. Beck Date: 3-17-2016 (mmm/dd/yyyy)

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U.S. Mailing Address: P.O. Box 179 Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Foresters Financial

Accelerated Death Benefit Rider Disclosure (This disclosure must be given to the owner.)

The insurance contract you are applying for may include one of the following accelerated death benefit riders: Accelerated Death Benefit Rider (for Chronic, Critical and Terminal Illness); Accelerated Death Benefit Rider (for Critical and Terminal Illness); or Accelerated Death Benefit Rider (for Terminal Illness). You should review the insurance contract issued, if any, to determine which one of these riders, if any, it includes. This disclosure provides only a brief description of the accelerated death benefit rider ("rider") that may be included in the insurance contract; it is not the rider and only the provisions of the rider, and the certificate that the rider is attached to, will control. A full description can be found within the certificate and rider issued, if any, therefore it is important that you read the certificate and rider carefully.

Benefit Description

The rider provides the opportunity for the owner to accelerate a portion of the certificate's eligible death benefit ("acceleration amount"), during the lifetime of the insured, and receive an accelerated death benefit payment ("payment"). Under the conditions described in the rider the owner may elect to receive a payment if the insured is diagnosed, by a physician, with a chronic, critical or terminal illness, as applicable under that rider. The payment is paid to the owner and not to the beneficiary(ies). The rider is not, and is not intended to be, long-term care insurance.

There is no required premium or monthly rider deduction, as applicable, for the rider. However, a payment may have deductions and other effects, as referred to in this disclosure.

Chronic illness means the insured:

a) Is unable to perform, without substantial assistance from another person, at least two of the activities of daily living (bathing, continence, dressing, eating, toileting or transferring) for a period of at least 90 days, due to a loss of functional capacity; or

b) Requires substantial supervision by another person to protect the insured from threats to health and safety due to the insured's severe cognitive impairment.

The chronic illness must be diagnosed by a physician as permanent.

Critical illness means the insured has one or more of the following, as defined in the rider: Advanced Alzheimer's Disease (before the insured's 75th birthday), Amyotrophic Lateral Sclerosis (ALS), End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack) or Stroke.

Terminal illness means the insured has a non-correctable illness or physical condition which is reasonably expected to result in death within 12 months of diagnosis.

Amount of the Accelerated Death Benefit Payment

The accelerated death benefit payment may be less than the acceleration amount as we may deduct from the acceleration amount: an actuarial discount amount, determined by us; an administrative fee; the sum of the unpaid total premium or overdue monthly deductions, as applicable; and a loan repayment amount, if there is an outstanding loan.

For terminal illness: The actuarial discount amount and administrative fee will both be $0.00. This means that the payment will only be less than the acceleration amount if, on the effective date of the payment, there are unpaid total premiums, overdue monthly deductions or an outstanding loan amount.

For chronic and critical illness: The administrative fee will be no more than $500.00. The actuarial discount amount will be determined by us based upon a number of factors, such as the insured's age and life expectancy on the effective date of the payment, and will take into account the present value of future anticipated premiums or monthly deductions, as applicable. This means that the payment will be less, and depending on the individual circumstances of the claim could be substantially less, than the acceleration amount.

Each acceleration amount must be at least $4,500.00 and must be such that after acceleration a residual face amount of at least $10,000.00 remains. The total of all acceleration amounts cannot exceed the lesser of 95% of the eligible death benefit on the effective date of the first payment and $500,000.00. For chronic illness the maximum amount that can be accelerated in any 12 month period is 24% of the eligible death benefit on the effective date of the first payment due to a chronic illness. For critical and terminal illness, the maximum amount that can be accelerated is 95% of the eligible death benefit on the effective date of the payment.

Effect of Payment on the Certificate

An accelerated death benefit payment will not end the certificate, however it will reduce the face amount and the amount, if any, of the paid-up additional insurance, account value or cash value, and loan amount on a pro-rata basis, based upon the acceleration amount. That payment will reduce the death benefit payable, if any, to the beneficiary(ies). The reduction to the face amount for chronic and critical illness will be more, and for terminal illness may be more, than the amount of the payment. Premiums or monthly deductions due, and dividends credited, after the effective date of the payment, will be adjusted based upon the reduced face amount. The adjusted premiums or monthly deductions, if any, will be as if the certificate had been issued at the reduced face amount.

The following example is hypothetical and is intended only to show the relationship between certificate values before and after payment of an accelerated death benefit. The example is based upon a whole life insurance certificate where an acceleration amount of 50% of the eligible death benefit has been approved.

	Before Acceleration	After Acceleration
Face Amount:	$100,000.00	$50,000.00
Amount of Paid-up Additional Insurance:	$ 20,000.00	$10,000.00
Eligible Death Benefit:	$120,000.00	$60,000.00
Cash Value:	$30,000.00	$15,000.00
Cash Value of Paid-up Additional Insurance:	$10,000.00	$ 5,000.00
Loan Amount:	$ 8,000.00	$ 4,000.00
Cash Surrender Value:	$32,000.00	$16,000.00
Annual Premium	$ 1,272.00	$ 672.00

Effect of Payment on Taxation and Eligibility for Public Assistance

Receipt of an accelerated death benefit payment under the rider is intended to qualify for favorable tax treatment under the Internal Revenue Code. However, depending on individual circumstances or changes to that code, receipt of an accelerated death benefit payment may be a taxable event. You should consult with a qualified tax advisor in order to assess the tax impact of receiving an accelerated death benefit payment.

Receipt of an accelerated death benefit payment may affect your, your spouse's or your family's eligibility for public assistance such as Medicaid, supplemental social security income or other government benefits or entitlements. You should consult each applicable government agency before receiving an accelerated death benefit payment so that you can assess the impact on eligibility for such assistance.

Producer Report

Proposed Insured

First name: JOHN Middle name: DOUG Last name: DOE

Producer's name	Producer #	% of split
CODY MICHAEL BECK	777777	100%

1. Indicate the anticipated rating class: SIMPLIFIED ISSUE
   If underwriting approval is for a rating class other than as anticipated, Foresters will contact you and, if we do not receive direction otherwise, the certificate will be issued to maintain face amount.
2. Should the certificate's issue date be adjusted to save the insurance age? ○ Yes ⊗ No
   If "Yes", additional premium may be required.
3. Is the proposed insured you, your spouse/partner or your child/stepchild? ○ Yes ⊗ No
4. In the Application, are you the owner, payer or beneficiary? ○ Yes ⊗ No
5. Have you submitted an additional application to Foresters on a family member of the proposed insured or owner (if other than the proposed insured)? ○ Yes ⊗ No
   If "Yes", list the name(s) in the Producer Comments section below.
6. Was a copy of the Buyer's Guide provided to the owner at the time of sale? ⊗ Yes ○ No
7. Indicate in the chart below if age & amount requirements were ordered (only if applying for a medically underwritten product).

Age & Amount Requirements	Vendor	Date ordered
Vitals, paramed or medical (with or without lab tests)		

Producer Comments (Can be used to provide additional information relevant to the Application and must be completed if needed to qualify statements in the Producer Certification section.)

We may require additional information for each "Yes" answer to a question in the Lifestyle, either Medical, or a Rider section. You can help speed up the Underwriting process by completing the questionnaire, from the list below, that is applicable to each "Yes" answer or if an applicable questionnaire is not available by providing details in the Additional Information section. Please refer to the Underwriting Guide for a list of all available questionnaires.

Alcohol Usage	Chest Pain	Cyst, Lump or Tumor
Diabetes	Drug and Substance Usage	Mental Health

This page is for internal use only and is not part of the Application.

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Foresters

APPENDIX A

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

(This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES _X_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES _X_ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

3. The existing policy or contract is being replaced because NO REPLACEMENT.

I certify that the responses herein are, to the best of my knowledge, accurate:

John D. Doe JOHN D. DOE
Applicant's Signature and Printed Name

3-17-2016
Date

Cody M. Beck CODY M. BECK
Producer's Signature and Printed Name

3-17-2016
Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)