

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
Project Name/Number: /

## Filing at a Glance

Company: The Independent Order of Foresters

Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed SERFF Tr Num: FRSS-126516328 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 45258

Sub-TOI: L08.000 Life - Other

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Jennifer Daigle, Kerry Shields, Tamara Kozma, Gita Lakhan, Art Vikari

Disposition Date: 06/14/2010

Date Submitted: 03/25/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Approval of these forms is not required by the Insurance Laws of Canada where this Society is domiciled.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/14/2010

Explanation for Other Group Market Type:

State Status Changed: 03/29/2010

Deemer Date:

Created By: Kerry Shields

Submitted By: Tamara Kozma

Corresponding Filing Tracking Number:

Filing Description:

RE: The Independent Order of Foresters

NAIC #763-58068; FEIN: 980000680

Form Type: Application for Life Insurance and related forms

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
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The forms listed below are enclosed for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal industry standards. Approval of these forms is not required by the Insurance Laws of Canada where this Society is domiciled.

Forms Submitted for Approval:

Form Number Form Description Form numbers if new form is replacing existing form.

Application for Life Insurance and related components

770630 US 02/10 Application for Individual Life Insurance 770206 AR 01/08  
 770148 US 02/10 Product Details – Lifefirst Term Life 770148 US 10/09  
 770331 US 02/10 Product Details – Strong Foundation Term Life 770331 US 10/09  
 770270 US 02/10 Product Details – Armor Universal Life 770270 US 03/08  
 770524 US 02/10 Product Details – BIG Universal Life 770524 US 11/08  
 770598 US 02/10 Product Details – SMART Universal Life 770598 US 10/09

Supplementary Related Forms

104907 US 02/10 Contingent Owner / Other Payer Identification 104907 US 01/08  
 104977 US 02/10 Medical Examination Report 104977 US 06/08

Supplementary Underwriting Questionnaires

101468 US 02/10 Activities of Daily Living Questionnaire 101468 US (06/04)  
 104030 US 02/10 Aerial Sports Questionnaire 104030 US (06/04)  
 105056 US 02/10 Alcohol Usage Questionnaire 101458 US (06/04)  
 105057 US 02/10 Arrhythmia/Atrial Fibrillation/Irregular Heartbeat Questionnaire NEW  
 101459 US 02/10 Arthritis Questionnaire 101459 US (06/04)  
 101461 US 02/10 Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder Questionnaire 101461 US (06/04)  
 104357 US 02/10 Aviation Questionnaire 104357 US (12/04)  
 105058 US 02/10 Back and Neck Questionnaire 101462 US (12/04)  
 105059 US 02/10 Benign Prostate Questionnaire NEW  
 101463 US 02/10 Business Financial Questionnaire 101463 US (06/04)  
 104024 US 02/10 Climbing and Mountaineering Questionnaire 104024 US (06/04)  
 105060 US 02/10 Chest Pain Questionnaire 101475 US (06/04)

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|   |                   |
|---|-------------------|
| 105065 US 02/10 Diabetes Questionnaire                      | 104023 US (06/04) |
| 104019 US 02/10 Cyst, Lump or Tumor Questionnaire           | 104019 US (06/04) |
| 105073 US 02/10 Digestive System Disorders Questionnaire    | 104022 US (06/04) |
| 105066 US 02/10 Drug and Substance Usage Questionnaire      | 101464 US (06/04) |
| 105068 US 02/10 Epilepsy and Seizure Disorder Questionnaire | 101474 US (12/04) |
| 104628 US 02/10 Foreign Travel Questionnaire                | 104628 US (10/05) |
| 105071 US 02/10 Heart Murmur Questionnaire                  | NEW               |
| 104020 US 02/10 High Blood Pressure Questionnaire           | 104020 US (06/04) |
| 104021 US 02/10 Kidney and Urinary Disorders Questionnaire  | 104021 US (06/04) |
| 105077 US 02/10 Lupus Questionnaire                         | NEW               |
| 105079 US 02/10 Mental Health Questionnaire                 | 101473 US (12/04) |
| 101472 US 02/10 Military Questionnaire                      | 101472 US (12/04) |
| 101467 US 02/10 Personal Financial Questionnaire            | 101467 US (06/04) |
| 105085 US 02/10 Prostate Cancer Questionnaire               | NEW               |
| 105086 US 02/10 Respiratory Disorders Questionnaire         | 101460 US (06/04) |
| 104033 US 02/10 Scuba and Skin Diving Questionnaire         | 104033 US (06/04) |
| 105089 US 02/10 Sleep Apnea/Sleep Disorder Questionnaire    | NEW               |
| 101470 US 02/10 Tobacco Questionnaire                       | 101470 US (12/04) |
| 104031 US 02/10 Hazardous Sports Questionnaire              | 104031 US (06/04) |

#### Supporting Documents:

Form Number Form Description  
770627 US 02/10 Notices (discusses MIB information and privacy rights)

This filing is undertaken in order to give our application package and supplemental forms a new look, and to make our forms more efficient and user – friendly for our applicants, administration and distribution groups.

We utilize a componentized application package, made up of the ‘Application for Individual Life Insurance’ and various product specific pages for product/rider selection, bound together as one package. Only those components that are relevant for the sale will be shown to the applicant and returned to us as part of the Application. For example, if an applicant applies for ‘SMART’ UL, only the SMART UL product page becomes part of the application. The other product details pages are not used. Application package contents vary –the package for a specific distribution group will only contain product pages applicable for sale by that group. All forms included in this filing will be utilized with our existing product portfolio approved in your state, and with new product filings as well, when appropriate.

The ‘Notices’, filed as a supporting document herein, will also be part of the bound package and will be left with the

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applicant at the time of sale. The Temporary Life Insurance Agreement, which is part of the Application for Individual Life Insurance, will also be left with the applicant if it will be in effect for the specific situation. An instructions page and producer report will also be bound with the package, and are intended for the convenience of producers and for internal use. They will not be a part of the application for contractual purposes, and are never shown to the applicant.

In addition to the forms that make up the filed components of the application package, we are also submitting related supplementary forms for approval.

- The Contingent Owner / Other Payer Identification form is used when a contingent owner or an alternate Payer is requested.
- The Medical Examination Report is used at the time of the paramedical exam, if one was required as a result of the product chosen and the applicant's data. Page 1 of that form is completed by the medical examiner and signed by the proposed insured/applicant. It contains the same medical questions as the application. Page 2 is used by the medical examiner to record the results of the physical exam.
- Thirty-one supplemental underwriting questionnaires are submitted for approval. A questionnaire may be completed at the time of the sale by the producer. Alternatively, if a need for a questionnaire is determined during our underwriting process, the questionnaire may be mailed to the applicant for completion, or an underwriter may phone the applicant and complete the form over the phone. If completed over the phone, the form is provided to the certificate owner along with the certificate, at the time of issue, to obtain the appropriate agreement/signatures.

These forms will be available as pre-printed, hard copy orderable forms, or as electronic PDFs. Electronic versions of all these forms may be downloaded, printed off and filled in by hand or may be filled out as a fill-able PDF, electronically. Application components are completed by the producer, and supplemental forms may be completed by the producer, the medical examiner or underwriter, as applicable. This may occur in person with the applicant and/or via telephone interview. In all cases the 'hardcopy' of the completed form will be provided to the applicant for review and applicable signatures.

The 'Application for Individual Life Insurance' contains the required 'Replacement' questions for both the applicant and the producer. If existing coverage or a replacement is disclosed, Foresters utilizes state-specific state-filed forms to meet all required replacement requirements in each state.

Depending on the method of generation and printing, the formatting and fonts may be slightly altered but all content will remain identical to the approved forms. The font size will never be less than the font size required.

If I may provide any additional information relating to this submission, please feel free to contact me at 416-429-3000, ext. 4922 or email [glakhan@foresters.com](mailto:glakhan@foresters.com)

Sincerely,

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 Project Name/Number: /  
 Gita Lakhan  
 Product Analyst

## Company and Contact

### Filing Contact Information

Kerry Shields, Compliance Analyst kshields@foresters.com  
 789 Don Mills Road 416-429-3000 [Phone] 4066 [Ext]  
 Toronto, ON M3C 1T9 416-467-2525 [FAX]

### Filing Company Information

The Independent Order of Foresters CoCode: 58068 State of Domicile: Ontario  
 789 Don Mills Road Group Code: -99 Company Type: Fraternal Benefit Society  
 Toronto, ON M3C 1T9 Group Name: State ID Number:  
 (416) 429-3000 ext. [Phone] FEIN Number: 98-0000680  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$1,950.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

| COMPANY                            | AMOUNT     | DATE PROCESSED | TRANSACTION # |
|------------------------------------|------------|----------------|---------------|
| The Independent Order of Foresters | \$1,950.00 | 03/25/2010     | 35152512      |

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## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 06/14/2010 | 06/14/2010     |
| Approved-Closed | Linda Bird | 04/07/2010 | 04/07/2010     |
| Approved-Closed | Linda Bird | 03/29/2010 | 03/29/2010     |

### Amendments

| Schedule            | Schedule Item Name                                 | Created By   | Created On | Date Submitted |
|---------------------|--|--------------|------------|----------------|
| Form                | Application for Individual Life Insurance          | Tamara Kozma | 06/03/2010 | 06/03/2010     |
| Supporting Document | Highlighted version of Application 770630 US 02/10 | Tamara Kozma | 06/03/2010 | 06/03/2010     |
| Form                | Product Details Page - Armor Universal             | Tamara Kozma | 04/07/2010 | 04/07/2010     |
| Form                | Product Details Page - BIG Universal               | Tamara Kozma | 04/07/2010 | 04/07/2010     |
| Form                | Product Details Page - SMART Universal Life        | Tamara Kozma | 04/07/2010 | 04/07/2010     |

### Filing Notes

| Subject                        | Note Type        | Created By    | Created On | Date Submitted |
|--------------------------------|------------------|---------------|------------|----------------|
| Request to Reopen this filing. | Note To Filer    | Linda Bird    | 06/03/2010 | 06/03/2010     |
| Request to Reopen this filing. | Note To Reviewer | Kerry Shields | 06/03/2010 | 06/03/2010     |

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Request To Re-Open Filing Note To Filer Linda Bird 04/06/2010 04/06/2010

Request to Re Open Filing FRSS- Note To Reviewer Kerry Shields 04/06/2010 04/06/2010  
126516328

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## Disposition

Disposition Date: 06/14/2010

Implementation Date:

Status: Approved-Closed

Comment: Company has revised form #770630 US 02/10.

Rate data does NOT apply to filing.

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 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
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| Schedule            | Schedule Item   | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification  |                      | Yes           |
| Supporting Document | Application   |                      | No            |
| Supporting Document | Notices   |                      | Yes           |
| Supporting Document | Highlighted version of Application 770630<br>US 02/10                                   |                      | Yes           |
| Form (revised)      | Application for Individual Life Insurance   |                      | Yes           |
| Form                | Application for Individual Life Insurance   | Replaced             | Yes           |
| Form                | Product Details Page - Lifefirst Term Life  |                      | Yes           |
| Form                | Product Details Page - Strong Foundation<br>Term Life                                   |                      | Yes           |
| Form (revised)      | Product Details Page - Armor Universal  |                      | Yes           |
| Form                | Product Details Page - Armor Universal  | Replaced             | Yes           |
| Form (revised)      | Product Details Page - BIG Universal  |                      | Yes           |
| Form                | Product Details Page - BIG Universal  | Replaced             | Yes           |
| Form (revised)      | Product Details Page - SMART Universal<br>Life  |                      | Yes           |
| Form                | Product Details Page - SMART Universal<br>Life  | Replaced             | Yes           |
| Form                | Contingent Owner/Other Payer<br>Identification  |                      | Yes           |
| Form                | Medical Examination Report  |                      | Yes           |
| Form                | Activities of Daily Living Questionnaire  |                      | Yes           |
| Form                | Aerial Sports Questionnaire   |                      | Yes           |
| Form                | Alcohol Usage Questionnaire   |                      | Yes           |
| Form                | Arrhythmia/Atrial Fibrillation/Irregular<br>Heartbeat Questionnaire                     |                      | Yes           |
| Form                | Arthritis Questionnaire   |                      | Yes           |
| Form                | Attention Deficit Hyperactivity Disorder or<br>Attention Deficit Disorder Questionnaire |                      | Yes           |
| Form                | Aviation Questionnaire  |                      | Yes           |
| Form                | Back and Neck Questionnaire   |                      | Yes           |
| Form                | Benign Prostate Questionnaire   |                      | Yes           |
| Form                | Business Financial Questionnaire  |                      | Yes           |
| Form                | Climbing and Mountaineering<br>Questionnaire  |                      | Yes           |
| Form                | Chest Pain Questionnaire  |                      | Yes           |

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|             |   |     |
|-------------|---|-----|
| <b>Form</b> | Diabetes Questionnaire                      | Yes |
| <b>Form</b> | Cyst, Lump or Tumor Questionnaire           | Yes |
| <b>Form</b> | Digestive System Disorders Questionnaire    | Yes |
| <b>Form</b> | Drug and Substance Usage Questionnaire      | Yes |
| <b>Form</b> | Epilepsy and Seizure Disorder Questionnaire | Yes |
| <b>Form</b> | Foreign Travel Questionnaire                | Yes |
| <b>Form</b> | Heart Murmur Questionnaire                  | Yes |
| <b>Form</b> | High Blood Pressure Questionnaire           | Yes |
| <b>Form</b> | Kidney and Urinary Disorders Questionnaire  | Yes |
| <b>Form</b> | Lupus Questionnaire                         | Yes |
| <b>Form</b> | Mental Health Questionnaire                 | Yes |
| <b>Form</b> | Military Questionnaire                      | Yes |
| <b>Form</b> | Personal Financial Questionnaire            | Yes |
| <b>Form</b> | Prostate Cancer Questionnaire               | Yes |
| <b>Form</b> | Respiratory Disorders Questionnaire         | Yes |
| <b>Form</b> | Scuba and Skin Diving Questionnaire         | Yes |
| <b>Form</b> | Sleep Apnea/Sleep Disorder Questionnaire    | Yes |
| <b>Form</b> | Tobacco Questionnaire                       | Yes |
| <b>Form</b> | Hazardous Sports Questionnaire              | Yes |

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## Disposition

Disposition Date: 04/07/2010

Implementation Date:

Status: Approved-Closed

Comment: Forms 770270 US 02/10, 770524 US 02/10 and 770598 US 02/10 have been revised to remove reference to the illustration certification.

Rate data does NOT apply to filing.

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| Schedule            | Schedule Item   | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification  |                      | Yes           |
| Supporting Document | Application   |                      | No            |
| Supporting Document | Notices   |                      | Yes           |
| Supporting Document | Highlighted version of Application 770630<br>US 02/10                                   |                      | Yes           |
| Form (revised)      | Application for Individual Life Insurance   |                      | Yes           |
| Form                | Application for Individual Life Insurance   | Replaced             | Yes           |
| Form                | Product Details Page - Lifefirst Term Life  |                      | Yes           |
| Form                | Product Details Page - Strong Foundation<br>Term Life                                   |                      | Yes           |
| Form (revised)      | Product Details Page - Armor Universal  |                      | Yes           |
| Form                | Product Details Page - Armor Universal  | Replaced             | Yes           |
| Form (revised)      | Product Details Page - BIG Universal  |                      | Yes           |
| Form                | Product Details Page - BIG Universal  | Replaced             | Yes           |
| Form (revised)      | Product Details Page - SMART Universal<br>Life  |                      | Yes           |
| Form                | Product Details Page - SMART Universal<br>Life  | Replaced             | Yes           |
| Form                | Contingent Owner/Other Payer<br>Identification  |                      | Yes           |
| Form                | Medical Examination Report  |                      | Yes           |
| Form                | Activities of Daily Living Questionnaire  |                      | Yes           |
| Form                | Aerial Sports Questionnaire   |                      | Yes           |
| Form                | Alcohol Usage Questionnaire   |                      | Yes           |
| Form                | Arrhythmia/Atrial Fibrillation/Irregular<br>Heartbeat Questionnaire                     |                      | Yes           |
| Form                | Arthritis Questionnaire   |                      | Yes           |
| Form                | Attention Deficit Hyperactivity Disorder or<br>Attention Deficit Disorder Questionnaire |                      | Yes           |
| Form                | Aviation Questionnaire  |                      | Yes           |
| Form                | Back and Neck Questionnaire   |                      | Yes           |
| Form                | Benign Prostate Questionnaire   |                      | Yes           |
| Form                | Business Financial Questionnaire  |                      | Yes           |
| Form                | Climbing and Mountaineering<br>Questionnaire  |                      | Yes           |
| Form                | Chest Pain Questionnaire  |                      | Yes           |

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| <b>Form</b> | Diabetes Questionnaire                      | Yes |
| <b>Form</b> | Cyst, Lump or Tumor Questionnaire           | Yes |
| <b>Form</b> | Digestive System Disorders Questionnaire    | Yes |
| <b>Form</b> | Drug and Substance Usage Questionnaire      | Yes |
| <b>Form</b> | Epilepsy and Seizure Disorder Questionnaire | Yes |
| <b>Form</b> | Foreign Travel Questionnaire                | Yes |
| <b>Form</b> | Heart Murmur Questionnaire                  | Yes |
| <b>Form</b> | High Blood Pressure Questionnaire           | Yes |
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| <b>Form</b> | Lupus Questionnaire                         | Yes |
| <b>Form</b> | Mental Health Questionnaire                 | Yes |
| <b>Form</b> | Military Questionnaire                      | Yes |
| <b>Form</b> | Personal Financial Questionnaire            | Yes |
| <b>Form</b> | Prostate Cancer Questionnaire               | Yes |
| <b>Form</b> | Respiratory Disorders Questionnaire         | Yes |
| <b>Form</b> | Scuba and Skin Diving Questionnaire         | Yes |
| <b>Form</b> | Sleep Apnea/Sleep Disorder Questionnaire    | Yes |
| <b>Form</b> | Tobacco Questionnaire                       | Yes |
| <b>Form</b> | Hazardous Sports Questionnaire              | Yes |

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## Disposition

Disposition Date: 03/29/2010

Implementation Date:

Status: Approved-Closed

Comment:

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| Form                | Activities of Daily Living Questionnaire  |                      | Yes           |
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| Form                | Back and Neck Questionnaire   |                      | Yes           |
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| <b>Form</b> | Diabetes Questionnaire                         | Yes |
| <b>Form</b> | Cyst, Lump or Tumor Questionnaire              | Yes |
| <b>Form</b> | Digestive System Disorders<br>Questionnaire    | Yes |
| <b>Form</b> | Drug and Substance Usage<br>Questionnaire      | Yes |
| <b>Form</b> | Epilepsy and Seizure Disorder<br>Questionnaire | Yes |
| <b>Form</b> | Foreign Travel Questionnaire                   | Yes |
| <b>Form</b> | Heart Murmur Questionnaire                     | Yes |
| <b>Form</b> | High Blood Pressure Questionnaire              | Yes |
| <b>Form</b> | Kidney and Urinary Disorders<br>Questionnaire  | Yes |
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| <b>Form</b> | Mental Health Questionnaire                    | Yes |
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| <b>Form</b> | Tobacco Questionnaire                          | Yes |
| <b>Form</b> | Hazardous Sports Questionnaire                 | Yes |

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**Amendment Letter**

Submitted Date: 06/03/2010

**Comments:**

Dear Ms Bird,

Thank you for reopening the above filing.

We have revised the base application form #770630 US 02/10 due to a typo on page 2, "Other Insurance Section", the word 'annuity' was missing.

We have attached both a clean and highlighted version of the base application form for your review and approval.

Should you have any questions please call me at 416-429-3000 ext. 4310

Yours truly,

Tamara Kozma  
 Product Compliance Analyst

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number     | Form Type                               | Form Name                                 | Action  | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments            |
|-----------------|---|---|---------|-------------------|-------------------|-----------------|-------------------|------------------------|
| 770630 US 02/10 | Application/EApplication nrollment Form | Application for Individual Life Insurance | Revised |                   | FRSS-125473789    | 770206 AR 01/08 | 50.000            | 770630 US 0210 App.pdf |

**Supporting Document Schedule Item Changes:**

**User Added -Name: Highlighted version of Application 770630 US 02/10**

Comment:

770630 US 0210 App HL.pdf

*SERFF Tracking Number:* FRSS-126516328      *State:* Arkansas  
*Filing Company:* The Independent Order of Foresters      *State Tracking Number:* 45258  
*Company Tracking Number:*  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
*Project Name/Number:* /

**Note To Filer**

**Created By:**

Linda Bird on 06/03/2010 11:38 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

06/03/2010 11:38 AM

**Subject:**

Request to Reopen this filing.

**Comments:**

Filing re-opened for amendment to form #770630 US 02/10.

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2010 Life Application, UL, Underwriting Questionnaires, Paramed  
Project Name/Number: /

**Note To Reviewer**

**Created By:**

Kerry Shields on 06/03/2010 10:55 AM

**Last Edited By:**

Kerry Shields

**Submitted On:**

06/03/2010 10:56 AM

**Subject:**

Request to Reopen this filing.

**Comments:**

We have realized that there is typo in the "Other Insurance Section" on page 2 of the base application form 770630 US 02/10, the word "annuity" is missing in the replacement questions. We are requesting that this filing be reopened in order to submit an amendment to form #770630 US 02/10.

Thanking you in advance for your assistance.

Kerry Shields

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

**Amendment Letter**

Submitted Date: 04/07/2010

**Comments:**

We have revised and attached forms 770270 US 02/10, 770524 US 02/10 and 770598 US 02/10 to remove reference to the illustration certification. Foresters utilizes a separate form to comply with all state requirements for illustration regulations. No other changes to the forms have been made. Our apologies for any inconvenience this may cause.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number     | Form Type                           | Form Name                           | Action  | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments              |
|-----------------|-------------------------------------|-------------------------------------|---------|-------------------|-------------------|-----------------|-------------------|--------------------------|
| 770270 US 02/10 | Application/EProduct nrollment Form | Details Page - Armor Universal      | Revised |                   | FRCS-125632915    | 770270 US 03/08 | 50.000            | 770270 US 0210 Armor.pdf |
| 770524 US 02/10 | Application/EProduct nrollment Form | Details Page - BIG Universal        | Revised |                   | FRCS-125833046    | 770524 US 11/08 | 50.000            | 770524 US 0210 BIG.pdf   |
| 770598 US 02/10 | Application/EProduct nrollment Form | Details Page - SMART Universal Life | Revised |                   | FRSS-126367689    | 770598 US 10/09 | 50.000            | 770598 US 0210 SMART.pdf |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
Project Name/Number: /

**Note To Filer**

**Created By:**

Linda Bird on 04/06/2010 01:51 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

04/06/2010 01:51 PM

**Subject:**

Request To Re-Open Filing

**Comments:**

Filing has been re-opened in order for corrections to be made.

*SERFF Tracking Number:* FRSS-126516328      *State:* Arkansas  
*Filing Company:* The Independent Order of Foresters      *State Tracking Number:* 45258  
*Company Tracking Number:*  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
*Project Name/Number:* /

**Note To Reviewer**

**Created By:**

Kerry Shields on 04/06/2010 11:47 AM

**Last Edited By:**

Kerry Shields

**Submitted On:**

04/06/2010 11:49 AM

**Subject:**

Request to Re Open Filing FRSS-126516328

**Comments:**

Dear Ms. Bird

Can you please reopen our filing, as we are revising our Universal Life Product Detail Pages to remove the reference to the illustration certification, Foresters utilizes a separate form to comply with all state requirements for illustration regulations.

Our apologies for any inconvenience this may cause.

Sincerely,

Kerry Shields  
Compliance Analyst

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

## Form Schedule

### Lead Form Number:

| Schedule Item Status | Form Number | Form Type                       | Form Name  | Action  | Action Specific Data  | Readability | Attachment                      |
|----------------------|-------------|---------------------------------|--|---------|---|-------------|---------------------------------|
|                      | 770630      | US Application/ Enrollment Form | Application for Individual Life Insurance          | Revised | Replaced Form #: 770206 AR 01/08<br>Previous Filing #: FRSS-125473789 | 50.000      | 770630 US 0210 App.pdf          |
|                      | 770148      | US Application/ Enrollment Form | Product Details Page - Lifefirst Term Life         | Revised | Replaced Form #: 770148 US 10/09<br>Previous Filing #: FRSS-126300515 | 50.000      | 770148 US 0210 LF.pdf           |
|                      | 770331      | US Application/ Enrollment Form | Product Details Page - Strong Foundation Term Life | Revised | Replaced Form #: 770331 US 10/09<br>Previous Filing #: FRSS-126300515 | 50.000      | 770331 US 0210 SF.pdf           |
|                      | 770270      | US Application/ Enrollment Form | Product Details Page - Armor Universal             | Revised | Replaced Form #: 770270 US 03/08<br>Previous Filing #: FRCS-125632915 | 50.000      | 770270 US 0210 Armor.pdf        |
|                      | 770524      | US Application/ Enrollment Form | Product Details Page - BIG Universal               | Revised | Replaced Form #: 770524 US 11/08<br>Previous Filing #: FRCS-125833046 | 50.000      | 770524 US 0210 BIG.pdf          |
|                      | 770598      | US Application/ Enrollment Form | Product Details Page - SMART Universal Life        | Revised | Replaced Form #: 770598 US 10/09<br>Previous Filing #: FRSS-126367689 | 50.000      | 770598 US 0210 SMART.pdf        |
|                      | 104907      | US Application/ Enrollment Form | Contingent Owner/Other Payer Identification        | Revised | Replaced Form #: 104907 US 01/08<br>Previous Filing #: FRSS-125473789 | 55.300      | 104907 US 0210 COwner payer.pdf |
|                      | 104977      | US Application/ Enrollment Form | Medical Examination                                | Revised | Replaced Form #:  | 54.000      | 104977 US                       |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application, UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

|                 |   |         |                        |        |   |
|-----------------|---|---------|------------------------|--------|---|
| 06/08           | Enrollment Report Form  |         | 104977 US 06/08        |        | 0210  |
|                 |   |         | Previous Filing #:     |        | Paramed.pdf   |
|                 |   |         | FRSS-125691411         |        |   |
| 101468 US 02/10 | Application/ Activities of Daily Enrollment Living Questionnaire Form                         | Revised | Replaced Form #:       | 53.300 | 101468 US 02-   |
|                 |   |         | 101468 US (06/04)      |        | 10_Activities of Daily Living Questionnaire .pdf                                      |
|                 |   |         | Previous Filing #:     |        |   |
|                 |   |         | Paper Filing -         |        |   |
|                 |   |         | Approved April 5, 2006 |        |   |
| 104030 US 02/10 | Application/ Aerial Sports Enrollment Questionnaire Form                                      | Revised | Replaced Form #:       | 50.600 | 104030 US 02-10_Aerial Sports Questionnaire .pdf                                      |
|                 |   |         | 104030 US (06/04)      |        |   |
|                 |   |         | Previous Filing #:     |        |   |
|                 |   |         | Paper Filing -         |        |   |
|                 |   |         | Approved April 5, 2006 |        |   |
| 105056 US 02/10 | Application/ Alcohol Usage Enrollment Questionnaire Form                                      | Revised | Replaced Form #:       | 52.000 | 105056 US 02-10_Alcohol Usage Questionnaire .pdf                                      |
|                 |   |         | 101458 US (06/04)      |        |   |
|                 |   |         | Previous Filing #:     |        |   |
|                 |   |         | Paper Filing -         |        |   |
|                 |   |         | Approved April 5, 2006 |        |   |
| 105057 US 02/10 | Application/ Arrhythmia/Atrial Enrollment Fibrillation/Irregular Form Heartbeat Questionnaire | Initial |                        | 52.500 | 105057 US 02-10_Arrhythmia_Atrial Fibrillation_Irregular Heartbeat Questionnaire .pdf |
|                 |   |         |                        |        |   |
| 101459 US 02/10 | Application/ Arthritis Enrollment Questionnaire Form  | Revised | Replaced Form #:       | 50.700 | 101459 US 02-10_Arthritis Questionnaire .pdf  |
|                 |   |         | 101459 US (06/04)      |        |   |
|                 |   |         | Previous Filing #:     |        |   |
|                 |   |         | Paper Filing -         |        |   |
|                 |   |         | Approved April 5, 2006 |        |   |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

|           |                                 |         |                    |        |               |
|-----------|---------------------------------|---------|--------------------|--------|---------------|
| 101461 US | Application/ Attention Deficit  | Revised | Replaced Form #:   | 50.400 | 101461 US     |
| 02/10     | Enrollment Hyperactivity        |         | 101461 US (06/04)  |        | 02-10_ADHD    |
|           | Form Disorder or Attention      |         | Previous Filing #: |        | & ADD         |
|           | Deficit Disorder                |         | Paper Filing -     |        | Questionnaire |
|           | Questionnaire                   |         | Approved April 5,  |        | .pdf          |
|           |                                 |         | 2006               |        |               |
| 104357 US | Application/ Aviation           | Revised | Replaced Form #:   | 50.500 | 104357 US     |
| 02/10     | Enrollment Questionnaire        |         | 104357 US (12/04)  |        | 02-           |
|           | Form                            |         | Previous Filing #: |        | 10_Aviation   |
|           |                                 |         | Paper Filing -     |        | Questionnaire |
|           |                                 |         | Approved April 5,  |        | .pdf          |
|           |                                 |         | 2006               |        |               |
| 105058 US | Application/ Back and Neck      | Revised | Replaced Form #:   | 52.900 | 105058 US     |
| 02/10     | Enrollment Questionnaire        |         | 101462 US (12/04)  |        | 02-10_Back &  |
|           | Form                            |         | Previous Filing #: |        | Neck          |
|           |                                 |         | Paper Filing -     |        | Questionnaire |
|           |                                 |         | Approved April 5,  |        | .pdf          |
|           |                                 |         | 2006               |        |               |
| 105059 US | Application/ Benign Prostate    | Initial |                    | 50.800 | 105059 US     |
| 02/10     | Enrollment Questionnaire        |         |                    |        | 02-10_Benign  |
|           | Form                            |         |                    |        | Prostate      |
|           |                                 |         |                    |        | Questionnaire |
|           |                                 |         |                    |        | .pdf          |
| 101463 US | Application/ Business Financial | Revised | Replaced Form #:   | 50.000 | 101463 US     |
| 02/10     | Enrollment Questionnaire        |         | 101463 US (06/04)  |        | 02-           |
|           | Form                            |         | Previous Filing #: |        | 10_Business   |
|           |                                 |         | Paper Filing -     |        | Financial     |
|           |                                 |         | Approved April 5,  |        | Questionnaire |
|           |                                 |         | 2006               |        | .pdf          |
| 104024 US | Application/ Climbing and       | Revised | Replaced Form #:   | 55.500 | 104024 US     |
| 02/10     | Enrollment Mountaineering       |         | 104024 US (06/04)  |        | 02-           |
|           | Form Questionnaire              |         | Previous Filing #: |        | 10_Climbing   |
|           |                                 |         | Paper Filing -     |        | and           |
|           |                                 |         | Approved April 5,  |        | Mountaineerin |
|           |                                 |         | 2006               |        | g             |
|           |                                 |         |                    |        | Questionnaire |
|           |                                 |         |                    |        | .pdf          |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

|   |         |   |  |
|---|---------|---|--|
| 105060 US Application/Chest Pain<br>02/10 Enrollment Questionnaire<br>Form                    | Revised | Replaced Form #: 50.000<br>101475 US (06/04)<br>Previous Filing #:<br>Paper Filing -<br>Approved April 5,<br>2006 | 105060 US<br>02-10_Chest<br>Pain<br>Questionnaire<br>.pdf                        |
| 105065 US Application/Diabetes<br>02/10 Enrollment Questionnaire<br>Form                      | Revised | Replaced Form #: 50.800<br>104023 US (06/04)<br>Previous Filing #:<br>Paper Filing -<br>Approved April 5,<br>2006 | 105065 US<br>02-<br>10_Diabetes<br>Questionnaire<br>.pdf                         |
| 104019 US Application/Cyst, Lump or Tumor<br>02/10 Enrollment Questionnaire<br>Form           | Revised | Replaced Form #: 56.000<br>104019 US (06/04)<br>Previous Filing #:<br>Paper Filing -<br>Approved April 5,<br>2006 | 104019 US<br>02-10_Cyst,<br>Lump or<br>Tumor<br>Questionnaire<br>.pdf            |
| 105073 US Application/Digestive System<br>02/10 Enrollment Disorders<br>Form Questionnaire    | Revised | Replaced Form #: 50.200<br>104022 US (06/04)<br>Previous Filing #:<br>Paper Filing -<br>Approved April 5,<br>2006 | 105073 US<br>02-<br>10_Digestive<br>System<br>Disorders<br>Questionnaire<br>.pdf |
| 105066 US Application/Drug and Substance<br>02/10 Enrollment Usage Questionnaire<br>Form      | Revised | Replaced Form #: 51.400<br>101464 US (06/04)<br>Previous Filing #:<br>Paper Filing -<br>Approved April 5,<br>2006 | 105066 US<br>02-10_Drug<br>and<br>Substance<br>Usage<br>Questionnaire<br>.pdf    |
| 105068 US Application/Epilepsy and Seizure<br>02/10 Enrollment Disorder<br>Form Questionnaire | Revised | Replaced Form #: 50.200<br>101474 US (12/04)<br>Previous Filing #:<br>Paper Filing -<br>Approved April 5,         | 105068 US<br>02-<br>10_Epilepsy<br>and Seizure<br>Disorder                       |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

| Application/Enrollment Form   | Status  | Year | Amount | File Name   |
|---|---------|------|--------|---|
| 104628 US Application/ Foreign Travel Enrollment Questionnaire Form               | Revised | 2006 | 52.800 | 104628 US 02-10_Foreign Travel Questionnaire .pdf               |
| 105071 US Application/ Heart Murmur Enrollment Questionnaire Form                 | Initial |      | 51.000 | 105071 US 02-10_Heart Murmur Questionnaire .pdf                 |
| 104020 US Application/ High Blood Pressure Enrollment Questionnaire Form          | Revised |      | 52.300 | 104020 US 02-10_High Blood Pressure Questionnaire .pdf          |
| 104021 US Application/ Kidney and Urinary Disorders Enrollment Questionnaire Form | Revised |      | 50.600 | 104021 US 02-10_Kidney and Urinary Disorders Questionnaire .pdf |
| 105077 US Application/ Lupus Questionnaire Enrollment Form                        | Initial |      | 50.500 | 105077 US 02-10_Lupus Questionnaire .pdf                        |
| 105079 US Application/ Mental Health Enrollment Questionnaire Form                | Revised |      | 50.500 | 105079 US 02-10_Mental Health Questionnaire .pdf                |
| 101472 US Application/ Military Enrollment Questionnaire                          | Revised |      | 53.200 | 101472 US 02-10_Military  |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

| Form                                      | 101472 US (12/04)       | Questionnaire |
|---|-------------------------|---------------|
|   | Previous Filing #:      | .pdf          |
|   | Paper Filing -          |               |
|   | Approved April 5,       |               |
|   | 2006                    |               |
| 101467 US Application/ Personal Financial | Revised                 | 101467 US     |
| 02/10 Enrollment Questionnaire            | Replaced Form #: 50.100 | 02-           |
| Form                                      | 101467 US (06/04)       | 10_Personal   |
|   | Previous Filing #:      | Financial     |
|   | Paper Filing -          | Questionnaire |
|   | Approved April 5,       | .pdf          |
|   | 2006                    |               |
| 105085 US Application/ Prostate Cancer    | Initial                 | 105085 US     |
| 02/10 Enrollment Questionnaire            |                         | 02-           |
| Form                                      |                         | 10_Prostate   |
|   |                         | Cancer        |
|   |                         | Questionnaire |
|   |                         | .pdf          |
| 105086 US Application/ Respiratory        | Revised                 | 105086 US     |
| 02/10 Enrollment Disorders                | Replaced Form #: 51.200 | 02-           |
| Form Questionnaire                        | 101460 US (06/04)       | 10_Respirator |
|   | Previous Filing #:      | y Disorders   |
|   | Paper Filing -          | Questionnaire |
|   | Approved April 5,       | .pdf          |
|   | 2006                    |               |
| 104033 US Application/ Scuba and Skin     | Revised                 | 104033 US     |
| 02/10 Enrollment Diving Questionnaire     | Replaced Form #: 53.400 | 02-10_Scuba   |
| Form                                      | 104033 US (06/04)       | and Skin      |
|   | Previous Filing #:      | Diving        |
|   | Paper Filing -          | Questionnaire |
|   | Approved April 5,       | .pdf          |
|   | 2006                    |               |
| 105089 US Application/ Sleep Apnea/Sleep  | Initial                 | 105089 US     |
| 02/10 Enrollment Disorder                 |                         | 02-10_Sleep   |
| Form Questionnaire                        |                         | Apnea-Sleep   |
|   |                         | Disorder      |
|   |                         | Questionnaire |
|   |                         | .pdf          |
| 101470 US Application/ Tobacco            | Revised                 | 101470 US     |
| 02/10 Enrollment Questionnaire            | Replaced Form #: 54.900 | 02-           |

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application, UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

|  |         |                    |                    |               |               |
|--|---------|--------------------|--------------------|---------------|---------------|
|  | Form    |                    | 101470 US (12/04)  |               | 10_Tobacco    |
|  |         |                    | Previous Filing #: |               | Questionnaire |
|  |         |                    | Paper Filing -     |               | .pdf          |
|  |         |                    | Approved April 5,  |               |               |
|  |         |                    | 2006               |               |               |
| 104031 US Application/Hazardous Sports | Revised | Replaced Form #:   | 50.600             | 104031 US     |               |
| 02/10 Enrollment Questionnaire         |         | 104031 US (06/04)  |                    | 02-           |               |
| Form                                   |         | Previous Filing #: |                    | 10_Hazardou   |               |
|  |         | Paper Filing -     |                    | s Sports      |               |
|  |         | Approved April 5,  |                    | Questionnaire |               |
|  |         | 2006               |                    | .pdf          |               |



## The Independent Order of Foresters ("Foresters")

### Application for Individual Life Insurance

| Proposed Insured   |  |  |  |  |
|--|--|--|--|--|
| First name:  | Middle name:   | Last name:   | <input type="radio"/> Male<br><input type="radio"/> Female |  |
| Street address (cannot be a P.O. Box.):  |  | City:  | State:   | Zip:   |
| Home phone #:  | Alternate phone # / Cell #:  | Best time to call:   | Date of birth (mmm/dd/yyyy):                               | State & Country of birth:  |
| Social Security #:   | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |  |  | Primary language:<br><input type="radio"/> English <input type="radio"/> Spanish |
| Type of Photo I.D. (used to verify identity):<br><input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government ID: _____<br>Photo I.D. # _____ |  |  |  |  |
| Occupation & duties:   |  | <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Seasonal |  |  |
| Hours worked per week (past 6 months): _____   |  | <input type="radio"/> Income (past 12 months): \$ _____  |  |  |
| Number of weeks worked in the past 12 months: _____  |  | <input type="radio"/> Net worth: \$ _____  |  |  |
| Foresters member?<br><input type="radio"/> Yes <input type="radio"/> No, applying for membership.  |  | Email address (optional):  |  |  |

### Beneficiary Information (Each beneficiary below is revocable. If, however, a beneficiary is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary.)

| Name of each primary beneficiary    | Relationship to proposed insured | % Share         |
|-------------------------------------|----------------------------------|-----------------|
|                                     |                                  | total           |
|                                     |                                  | must equal      |
|                                     |                                  | 100%            |
| Name of each contingent beneficiary | Relationship to proposed insured | % Share         |
|                                     |                                  | total           |
|                                     |                                  | must equal 100% |

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

|  |                              |  |        |      |
|--|------------------------------|--|--------|------|
| Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust: |                              | Social Security # / Tax I.D. #:  |        |      |
| Street address (cannot be a P.O. Box.):  |                              | City:  | State: | Zip: |
| Relationship to the proposed insured:  |                              | Email address (optional):  |        |      |
| Phone #:   | If Trust, name of Trustee:   | If Trust, date of Trust agreement:   |        |      |
| If Individual  |                              |  |        |      |
| <input type="radio"/> Male<br><input type="radio"/> Female                                     | Date of birth (mmm/dd/yyyy): | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |        |      |

## Other Insurance

|   |                           |                     |                     |                                  |  |
|---|---------------------------|---------------------|---------------------|----------------------------------|--|
| 1. Is there another annuity or life insurance application pending for the proposed insured with Foresters or another insurer?   |                           |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 2. Does the proposed insured currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force?<br>If "Yes", to either question 1 or 2, complete the chart below. Also include information about Foresters life insurance or annuity certificate(s).   |                           |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| Name of Insurer   | Annuity/Life insurance \$ | Accidental death \$ | Critical illness \$ | Disability income (per month) \$ | Issue year or indicate if pending                  |
|   |                           |                     |                     |                                  |  |
|   |                           |                     |                     |                                  |  |
| 3. Has the proposed insured ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date _____ and reason _____   |                           |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 4. 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)?   |                           |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 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. Check the State requirements as these would need to be satisfied before the certificate can be issued. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those completed within the past 13 months. |                           |                     |                     |                                  |  |

For purposes of this Application, "diagnosed," "advised" and "treatment" mean by a licensed physician or medical practitioner.

## Children's Questions (Complete only if applying for Children's Term Coverage.)

| Name of child (First, Middle, Last) under 18 years old<br>(must be a child of the proposed insured)   | Gender<br>(M or F) | Date of birth<br>(mmm/dd/yyyy)                   | Height<br>(ft/in)                     | Weight<br>(lbs) | Amount of coverage<br>in force   |
|---|--------------------|--|---------------------------------------|-----------------|--|
|   |                    |  |                                       |                 |  |
|   |                    |  |                                       |                 |  |
| 5. Has a child listed above:<br>a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease?<br>b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for Human Immunodeficiency Virus (HIV)) that has not yet been started or completed, or the results of which are not yet known?<br>If "Yes", to either question 5a or 5b, complete the chart below. |                    |  |                                       |                 | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |
| Question #  | Name of child      | Diagnosis, date(s), treatment, present condition | Physician's name, address and phone # |                 |  |
|   |                    |  |                                       |                 |  |
|   |                    |  |                                       |                 |  |
|   |                    |  |                                       |                 |  |

## Financial Questions

|   |  |  |
|---|--|--|
| 6. Is there an intention, or an arrangement, that all or part of the insurance applied for will be:<br>a) Paid for by borrowing, financing or receiving money or any other property?<br>b) Transferred, assigned, sold or pledged?<br>If "Yes", to either question 6a or 6b provide details. _____<br>_____ |  | <input type="radio"/> Yes <input type="radio"/> No<br><input type="radio"/> Yes <input type="radio"/> No |
| 7. Has the proposed insured, owner or a beneficiary arranged, been offered, or received, an inducement, fee or compensation to buy, or pay for, the insurance applied for? If "Yes", provide details. _____<br>_____  |  | <input type="radio"/> Yes <input type="radio"/> No   |

For each "Yes" answer in the Lifestyle and Medical Questions sections additional information may be required. Completing the corresponding questionnaire or, if no corresponding questionnaire is available, providing details in the Additional Information section may help speed up the Underwriting process.

| <b>Lifestyle Questions (For these questions "You" and "Your" mean the proposed insured.)</b>   |  |
|--|--|
| 8. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify:<br>Type used: _____ Date last used: _____<br>If currently smoking, how many pack(s) per day? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 9. Do you currently drink alcohol? If "Yes", specify:<br>How many times per week? _____ How many drinks per occasion? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 10. Within the past 10 years have you:<br>a) Used marijuana, heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or a controlled substance except as prescribed by a licensed physician or medical practitioner?<br>b) Received or been advised to receive treatment or counseling, by a licensed physician or medical practitioner, to discontinue or reduce the use of alcohol, non-prescribed or prescribed drugs? | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |
| 11. Do you expect to travel outside of North America or change your country of residence within the next 2 years?  | <input type="radio"/> Yes <input type="radio"/> No   |
| 12. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 13. Have you, within the past 2 years, flown, or do you in the future intend to fly, in an aircraft as a student pilot, licensed pilot or crew member?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 14. Have you, within the past 2 years, engaged, or do you in the future intend to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 15. Have you ever had your driver's license suspended or revoked or within the past 5 years had more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____<br>_____   | <input type="radio"/> Yes <input type="radio"/> No   |
| 16. Within the past 10 years have you:<br>a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", provide date, details and State where each conviction occurred. _____<br>_____<br>b) Been convicted of, pled guilty to, or are you currently on probation or incarcerated for, a felony? If "Yes", provide date(s) and reason(s). _____<br>_____                                | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |

| <b>Medical Questions (For these questions "You" and "Your" mean the proposed insured. For each "Yes" answer, provide details in the Additional Information section.)</b>   |  |
|--|--|
| 17.<br>a) Your: Height: _____ Weight: _____<br>b) Have you had a weight change of 10 pounds or more, within the past 12 months? If "Yes", specify: <input type="radio"/> Gain <input type="radio"/> Loss<br>How many pounds? _____ Reason: _____ | <input type="radio"/> Yes <input type="radio"/> No |
| 18. Date you last consulted a physician: _____<br>Physician Name: _____ Address: _____<br>a) Reason(s): _____<br>b) Were results of that consultation within normal ranges? If "No," provide details. _____                                      | <input type="radio"/> Yes <input type="radio"/> No |

|  |                |               |                                       |
|--|----------------|---------------|---------------------------------------|
| 19. Your Personal Physician(s), if different than question 18.<br>Name: _____ Address: _____ Phone #: _____<br>Name: _____ Address: _____ Phone #: _____   |                |               |                                       |
| 20. Within the past 5 years, have you consulted a physician other than identified in question 18 or 19, or a medical practitioner, or been a clinic, hospital or emergency room patient?   |                |               | O Yes O No                            |
| 21. Are you presently taking prescription medication or under treatment?   |                |               | O Yes O No                            |
| 22. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?   |                |               | O Yes O No                            |
| 23. Do you have, alive or deceased, a parent or sibling with a history, prior to age 65, of diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, or other hereditary disorder?<br>Details to "Yes" answers to question 23.  |                |               | O Yes O No                            |
|  | Age, if living | Age, at death | Details of condition / Cause of death |
| Father   |                |               |                                       |
| Mother   |                |               |                                       |
| Siblings   |                |               |                                       |
| 24. Within the past 5 years, have you:<br>a) Had or been advised to have a diagnostic test (other than for HIV) such as an EKG, CAT scan, MRI scan, echocardiogram, angiogram, biopsy, or endoscopy?   |                |               | O Yes O 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?   |                |               | O Yes O No                            |
| c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?  |                |               | O Yes O 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:<br>a) High blood pressure, coronary artery disease, heart murmur, chest pain, irregular heart beat, aneurysm, stroke, Transient Ischemic Attack, circulatory surgery, a disease or disorder of the arteries or circulatory system or had a heart attack or heart surgery? |                |               | O Yes O No                            |
| b) Anemia, high cholesterol, swollen glands or a disease or disorder of the blood or lymphatic system?   |                |               | O Yes O No                            |
| c) Cancer, tumor, polyp, cyst, melanoma, unexplained swelling or lump or a malignancy?   |                |               | O Yes O No                            |
| d) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, chronic cough, sleep apnea, or a disease or disorder of the respiratory system?   |                |               | O Yes O No                            |
| e) Seizures, epilepsy, dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, or a disease or disorder of the brain or nervous system?   |                |               | O Yes O No                            |
| f) Anxiety, depression, bi-polar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder (PTSD) or a mental health disorder?  |                |               | O Yes O No                            |
| g) Blood or albumin in the urine or a disease or disorder of the prostate, bladder, kidney or genito-urinary organ?  |                |               | O Yes O No                            |
| h) Diabetes, or a disease or disorder of the thyroid, pituitary, pancreas or endocrine system?   |                |               | O Yes O No                            |
| i) Hepatitis, colitis, ileitis, gastritis, ulcer, Crohn's disease or a disease or disorder of the digestive system?  |                |               | O Yes O No                            |
| j) Arthritis, fibromyalgia, or a disease or disorder of the back, neck or musculoskeletal system?  |                |               | O Yes O No                            |
| k) Lupus or a disease or disorder of the immune system (other than HIV) or connective tissue?  |                |               | O Yes O No                            |

| <b>Additional Information (Explain all "Yes" answers from the Medical Questions section.)</b> |   |
|---|---|
| Question #  | State diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone numbers (if different than question 19). |
|   |   |
|   |   |
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|   |   |
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|   |   |
|   |   |
|   |   |

## Payment Information and Authorization

The planned premium quoted may change following underwriting review.

|  |  |  |
|--|--|--|
| Payer is:                              |  |  |
| <input type="radio"/> Proposed insured | <input type="radio"/> Owner (if other than proposed insured) | <input type="radio"/> Other (complete Contingent Owner/Other Payer Form) |

|  |  |
|--|--|
| First premium payment to be made by:                       |  |
| <input type="radio"/> Draft via Pre-Authorized Check (PAC) | <input type="radio"/> Check (payable to Foresters) |

|                                      |                                   |
|--------------------------------------|-----------------------------------|
| Subsequent premium payments made by: |                                   |
| <input type="radio"/> PAC            | <input type="radio"/> Direct Bill |

|  |                                 |                                     |                                |
|--|---------------------------------|-------------------------------------|--------------------------------|
| Payment mode:                            |                                 |                                     |                                |
| <input type="radio"/> Monthly (PAC only) | <input type="radio"/> Quarterly | <input type="radio"/> Semi-annually | <input type="radio"/> Annually |

|   |   |   |
|---|---|---|
| PAC banking information (including drafting first premium) to be taken from:  |   |   |
| <input type="radio"/> Attached void check                                     | <input type="radio"/> Check submitted with this Application | <input type="radio"/> Information completed below (if no check available) |
| Type of account: <input type="radio"/> Checking <input type="radio"/> Savings |   |   |
| Name of financial institution: _____  |   |   |
| Street address: _____   |   |   |
| City: _____ State: _____ Zip: _____   |   |   |
| Transit #: _____ Account #: _____   |   |   |

### 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 and agrees that: 1) Foresters is authorized to draft deductions under the PAC plan from that account or another account later identified or substituted by the payer. 2) The financial institution from which payments 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, if any, will be made and the amount of that deduction for the product issued. 4) This PAC plan 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 agreement must be signed by the bank account owner as his/her name appears on bank records for the account provided.

X \_\_\_\_\_  
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.

### Temporary Life Insurance Agreement (TIA) Questions

|   |  |
|---|--|
| 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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

### Temporary Life Insurance Agreement (TIA) Acknowledgement

Will the TIA be left with the owner?

No. The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided or authorized.      X \_\_\_\_\_  
(Owner's initials)

Yes. Complete the TIA and leave it with the owner.  
 First premium payment, in the amount of \$ \_\_\_\_\_, is provided or authorized by (select same method chosen in the Payment Information and Authorization section):

Draft via Pre-Authorized Check (PAC) plan  
 Check

Although the first 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 applied for in this Application and is payable no later than the date this Application is signed.

### Declarations and Agreements

"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 in this Application, declare that: 1) I have read 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.

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 with Foresters. 3) No person, including a producer, has the authority to waive the disclosure of full, complete and truthful information or write down an answer to a question in this Application other than the answer provided to that person. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) Failure to disclose all material facts may result in a loss of coverage and cancellation of the insurance contract. A material misrepresentation or untrue declaration may render the insurance contract issued, if any, voidable. All facts should be shown in this Application. 6) The insurance contract issued, if at all, as a result of this Application, is conditional on there being no change in the insurability of the proposed insured, or a child identified in this Application, if any, between the date this Application was signed by the proposed insured and the date that the insurance contract comes into effect, being either the issue date or delivery date of the insurance contract according to its terms. 7) 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.

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, including but not limited to, email and facsimile 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) If I have chosen to provide a current internet 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 and with intent to defraud Foresters, any other insurer, or other person(s), files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**Temporary Life Insurance Agreement (TIA) (Complete and leave with the owner only if all pre-conditions are met.)**

**Definitions** - "Application" means the Application for Individual Life Insurance of which this Agreement forms a part. "Producer" means the person who signed the Application as the producer. "Proposed Insured" and "Owner" mean the person(s) identified as such in the Application.

**Pre-Conditions to Temporary Coverage** - Subject to the terms of this Agreement, Foresters agrees to provide the temporary coverage set out in this Agreement, effective on the date the Application is signed by the owner, if each of the following pre-conditions are met: 1) The proposed insured is not age 71 or older on that date. 2) No more than \$1,000,000 insurance coverage on the life of the proposed insured is applied for in the Application, calculated by including the amount of the benefit applied for under each rider (except common carrier accidental death coverage if any) that is payable in the event of death of the proposed insured. 3) Each of the Temporary Life Insurance Agreement questions are answered 'No' and the 'No' answers shown are truthful and 4) No later than the date the Application is signed by the owner, first payment, at least equal to a monthly premium quoted for the insurance applied for in the Application, is provided or authorized. If one or more of the above pre-conditions are not met, no temporary coverage takes effect even if this Agreement was left with the owner.

**Temporary Life Insurance Agreement Questions**

|   |  |
|---|--|
| 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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

**Amount of Temporary Coverage** - Subject to the terms of this Agreement, if all of the above pre-conditions are met and the proposed insured dies while this Agreement is in effect, Foresters shall pay, to the beneficiary(ies), as shown in the Application, under this and all other Foresters temporary life insurance agreement(s) insuring the life of the proposed insured, the lesser of a) \$500,000; or, b) the amount of insurance applied for in the Application on the life of the deceased proposed insured, including the amount payable for the death of the proposed insured under a rider applied for (except common carrier accidental death coverage if any).

**Termination of Temporary Coverage** - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate on the life of the proposed insured takes effect as described in that certificate, if a certificate is issued in response to the Application. 3) The date Foresters offers, as shown in Foresters records, the owner a Foresters certificate in response to, but not as applied for in, the Application. 4) The date a written or oral request to withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 5) The date written notice is sent by Foresters, as shown in Foresters records, to the proposed insured or the owner, terminating this Agreement or declining the Application.

**Special Limitations** - This Agreement shall be void if the first payment, regardless of method, is not honored when presented for payment. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Foresters liability to a refund of payment(s) made to Foresters. If the proposed insured dies by suicide, whether sane or insane, Foresters liability under this Agreement is limited to a refund of the payment(s) made to Foresters.

**Entire Agreement and Governing Law** - This Agreement contains the entire terms regarding temporary coverage. No one, including the producer, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement. This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

**Acknowledgement** - I, the proposed insured and owner, if other than the proposed insured, by signing in the Signature Section of the Application, acknowledge and agree that I have reviewed, understand and accept the terms of this Temporary Life Insurance Agreement.

Countersigned,



George Mohacsi, President & Chief Executive Officer

## Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims and c) supporting the operations of our business. In this authorization, "proposed insured" means the proposed insured identified in this Application. "Child" means every child named, if any, and proposed for insurance, in this Application. 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, authorizes Foresters, its reinsurers and those who perform services for Foresters related to an application for insurance or a claim for benefits, to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; other insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or Medical Information Bureau, Inc ('MIB, Inc.'). 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. Foresters may make a brief report to MIB, Inc. about the proposed insured and each child. Foresters or its authorized representatives may disclose information to: its reinsurers; appointed producers, agencies and those who perform services for Foresters related to an application for insurance or a claim for benefits; or those companies to which the proposed insured has applied or may apply to for life or health insurance, or benefits. Disclosure may be made when required or permitted by law and the disclosed information may no longer be protected by federal privacy laws. This authorization shall be the consent required, whether implied or express, written or oral, by applicable law(s), including Federal and state legislation and regulations regarding the collection, retention, usage and disclosure of information about or related to the proposed insured, owner and each child. This authorization is valid for two years from the date of this Application. Foresters or its authorized representatives may use an original document or a copy of this authorization to obtain information. This authorization may be revoked at any time by written notice to Foresters, except that action(s) taken before written revocation will not be affected. A Notices page has been provided to the proposed insured. It includes the MIB, Inc. and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

## Signature Section (For purposes of entire Application.)

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of owner (if other than proposed insured)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile  
and the owner is not a parent/guardian)

Each person signed at: \_\_\_\_\_  
(City, State)

Each person signed on: \_\_\_\_\_  
Date (mmm/dd/yyyy)

## 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 that might affect insurability; b) I personally met with the proposed insured and each child and asked the proposed insured and/or the owner each question as written in this Application to which an answer is shown, recorded those answers given to me by the proposed insured and owner, reviewed with each this Application before it was signed by that person, reviewed the document(s) used to verify identity and birth date and witnessed each signature in this Application; c) This Application has not been altered in any way after the proposed insured and owner signed it; d) 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; e) If applicable, I have disclosed that this Application may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission; f) 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.

Will the certificate applied for be a replacement for or change existing insurance or an annuity?

Yes  No

Are you related to the proposed insured?

Yes  No

\_\_\_\_\_  
Producer's full name

\_\_\_\_\_  
Producer #

X \_\_\_\_\_  
Signature of producer

\_\_\_\_\_  
Date (mmm/dd/yyyy)

## The Independent Order of Foresters ("Foresters")

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

|  |
|--|
| <b>Proposed Insured</b><br><br>First name: _____ Middle name: _____ Last name: _____ |
|--|

### Lifefirst Term Life

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____ | Term: <input type="radio"/> 10 year <input type="radio"/> 20 year <input type="radio"/> 30 year |
|---|---|

|  |  |   |
|--|--|---|
| <b>Riders (Subject to state and product availability.)</b>   |  |   |
| <input type="radio"/> Disability income (accident and sickness): \$ _____ OR <input type="radio"/> Disability income (accident only): \$ _____<br>If Disability income (accident and sickness) applied for but not approved, applying for Disability income (accident only)?<br><input type="radio"/> Yes <input type="radio"/> No |  |   |
| <input type="radio"/> Accidental death:<br>\$ _____  | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Critical illness (accelerated death benefit):<br>\$ _____ |
| <input type="radio"/> First rewards  | <input type="radio"/> Waiver of premium            | <input type="radio"/> Other rider(s) :<br>_____                                 |

|   |
|---|
| <b>Remarks:</b>   |
|   |
|   |
|   |
| 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.



## The Independent Order of Foresters ("Foresters")

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

|  |
|--|
| <b>Proposed Insured</b><br><br>First name: _____ Middle name: _____ Last name: _____ |
|--|

### Strong Foundation Term Life

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured: \$ _____  |   |
| Simplified Issue<br>Term: <input type="radio"/> 15 year <input type="radio"/> 20 year <input type="radio"/> 30 year | Fully Underwritten<br>Term: <input type="radio"/> 10 year <input type="radio"/> 15 year <input type="radio"/> 20 year <input type="radio"/> 30 year |

|   |   |  |
|---|---|--|
| <b>Riders (Subject to state and product availability.)</b>  |   |  |
| <input type="radio"/> Accidental death  |   |  |
| Percentage of face amount: <input type="radio"/> 25% <input type="radio"/> 50% <input type="radio"/> 75% <input type="radio"/> 100% |   |  |
| <input type="radio"/> Children's term<br>\$ 10,000.00   | <input type="radio"/> Critical illness (accelerated death benefit):<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Living rewards  | <input type="radio"/> Waiver of premium   | <input type="radio"/> Other rider(s):<br>_____                       |

|  |
|--|
| <b>Remarks:</b><br><br>_____<br>_____<br>_____<br>_____<br>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.

## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for universal life insurance with lifetime no-lapse guarantee provision.)

|   |
|---|
| <b>Proposed Insured</b>                               |
| First name: _____ Middle name: _____ Last name: _____ |

### Armor Universal Life (with lifetime no-lapse guarantee provision)

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____ | Planned premium: <input type="radio"/> Monthly <input type="radio"/> Quarterly<br>\$ _____ <input type="radio"/> Semi-annually <input type="radio"/> Annually |
| Initial lump sum premium:<br>\$ _____                                     | Source of lump sum premium:<br>_____  |

|   |   |  |
|---|---|--|
| <b>Riders (Subject to state and product availability.)</b>  |   |  |
| <input type="radio"/> Accidental death  | Percentage of face amount: <input type="radio"/> 25% <input type="radio"/> 50% <input type="radio"/> 75% <input type="radio"/> 100% |  |
| <input type="radio"/> Cost of living adjustment   | <input type="radio"/> Guaranteed purchase option  | <input type="radio"/> Waiver of premium        |
| <input type="radio"/> Children's term:<br>\$ _____  | <input type="radio"/> Disability income (accident only):<br>\$ _____  | <input type="radio"/> Other rider(s):<br>_____ |
| <input type="radio"/> Charity Percentage of face amount: <input type="radio"/> 5% <input type="radio"/> 10% <input type="radio"/> 15% |   |  |
| Indicate beneficiary below (must be a registered charity):  |   |  |
| <input type="radio"/> Children's Miracle Network (CMN)  |   |  |
| <input type="radio"/> Other: _____ (Name) _____ (Registered charity #, if available)  |   |  |
| _____ (Address)   |   |  |

|  |          |
|--|----------|
| <b>Complete if the proposed insured is a juvenile.</b>   |          |
| a) State amount of life insurance on primary caregiver.  | \$ _____ |
| b) Are all brothers and sisters insured for the same amount? If "No," state amount and reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No |          |
| c) Does the child live with the owner? If "No," provide reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No                                |          |

|   |
|---|
| <b>Remarks:</b>   |
|   |
| 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.



## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for universal life insurance with lifetime no-lapse guarantee provision.)

|   |
|---|
| <b>Proposed Insured</b>                               |
| First name: _____ Middle name: _____ Last name: _____ |

### BIG Universal Life (with lifetime no-lapse guarantee provision.)

|   |  |
|---|--|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____ | Planned premium: <input type="radio"/> Monthly <input type="radio"/> Quarterly<br><input type="radio"/> Semi-annually <input type="radio"/> Annually<br>\$ _____ |
| Initial lump sum premium:<br>\$ _____                                     | Source of lump sum premium:<br>_____   |

|  |  |  |
|--|--|--|
| <b>Riders (Subject to state and product availability.)</b> |  |  |
| <input type="radio"/> Accidental death:<br>\$ _____        | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Waiver of premium                    |  | <input type="radio"/> Other rider(s): _____                          |

|   |
|---|
| <b>Remarks:</b>   |
|   |
|   |
|   |
| 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.

## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for SMART Universal Life insurance.)

|   |
|---|
| Proposed Insured                                      |
| First name: _____ Middle name: _____ Last name: _____ |

### SMART Universal Life

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____   | Planned premium: <input type="radio"/> Monthly <input type="radio"/> Quarterly<br>\$ _____ <input type="radio"/> Semi-annually <input type="radio"/> Annually |
| Life insurance qualification test:<br><input type="radio"/> Guideline Premium Test (GPT)<br><input type="radio"/> Cash Value Accumulation Test (CVAT) | Death benefit option:<br><input type="radio"/> Level<br><input type="radio"/> Increasing  |
| Initial lump sum premium:<br>\$ _____   | Source of lump sum premium:<br>_____  |

|  |  |  |
|--|--|--|
| <b>Riders (Subject to state and product availability.)</b> |  |  |
| <input type="radio"/> Accidental death:<br>\$ _____        | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Waiver of monthly deductions         |  | <input type="radio"/> Guaranteed purchase option                     |
| <input type="radio"/> Other rider(s): _____                |  |  |

|  |          |
|--|----------|
| <b>Complete if the proposed insured is a juvenile.</b>   |          |
| a) State amount of life insurance on primary caregiver.  | \$ _____ |
| b) Are all brothers and sisters insured for the same amount? If "No," state amount and reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No |          |
| c) Does the child live with the owner? If "No," provide reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No                                |          |

|   |
|---|
| Remarks:  |
|   |
| 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.



## The Independent Order of Foresters ("Foresters")

### Contingent Owner/Other Payer Identification Form

For purposes of this form, "Application" means the Foresters application for insurance on the proposed insured, and "I" means individually each person identified in that Application as either the proposed insured or the owner.

#### Proposed Insured

|            |             |           |
|------------|-------------|-----------|
| First name | Middle name | Last name |
|------------|-------------|-----------|

#### Contingent Owner /Other Payer Information. (Complete this section to designate a Contingent Owner or to identify a payer other than the proposed insured or the owner.)

|   |                                |   |                                    |
|---|--------------------------------|---|------------------------------------|
| Intent of this form (select one): <input type="radio"/> Designation of Contingent Owner. <input type="radio"/> Identify a payer other than the proposed insured or the owner. |                                |   |                                    |
| Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust:  |                                |   | If Trust, date of Trust agreement: |
| Street address (cannot be a P.O. Box.)  |                                | City  | State Zip                          |
| Phone #   | Social Security # / Tax I.D. # | Relationship to the proposed insured  | Email address (optional)           |
| If Trust, name and address of trustee:  |                                |   |                                    |
| If Contingent Owner or Other Payer is an individual, complete the following:  |                                |   |                                    |
| <input type="radio"/> Male  | Date of birth (mmm/dd/yyyy)    | U.S. citizen?   |                                    |
| <input type="radio"/> Female  |                                | <input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |                                    |

#### Additional Other Payer Information. (Answer the following questions when using this form to identify a payer other than the proposed insured or the owner.)

|  |
|--|
| Is the payer paying the premium as a loan or for financing to, or will it create a debt by, the insured or owner or is there an intent or arrangement that the payer will be paid back the premium? <input type="radio"/> Yes <input type="radio"/> No<br>If yes, provide details: _____               |
| Is there an agreement or understanding that the insurance applied for will be assigned, pledged or transferred to the payer or that the payer will receive a fee, compensation or benefit for paying the premium? <input type="radio"/> Yes <input type="radio"/> No<br>If yes, provide details: _____ |

I understand that this Contingent Owner/Other Payer Form is part of and is subject to the Application.

\_\_\_\_\_  
 Signature of proposed insured.

\_\_\_\_\_  
 Signature of owner (if other than proposed insured).

\_\_\_\_\_  
 Producer's name (print full name)

\_\_\_\_\_  
 Producer number

\_\_\_\_\_  
 Producer's signature

Each person signed at: \_\_\_\_\_

This form is part of the Application

**Medical Examination Report** If additional space needed, attach additional pages, signed by Proposed Insured.

|                             |                       |                              |
|-----------------------------|-----------------------|------------------------------|
| Proposed Insured Last name. | First name & initial. | Date of Birth. (mmm/dd/yyyy) |
|-----------------------------|-----------------------|------------------------------|

Name and address of your personal physician. (If none, so state.) \_\_\_\_\_

Date and reason last consulted. \_\_\_\_\_

What treatment was given or medication prescribed? \_\_\_\_\_

For purposes of page 1 of this form, "You" and "Your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured. "Diagnosed", "advised" and "treatment" mean by a licensed physician or medical practitioner.

1. Within the past 5 years, have you consulted with a physician other than identified above, or a medical practitioner, or been a clinic, hospital or emergency room patient?  Yes  No
2. Are you presently taking prescription medication or under treatment?  Yes  No
3. 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
4. Do you have, alive or deceased, a parent or sibling with a history, prior to age 65, of diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, or other hereditary disorder?  Yes  No

Details to "Yes" answers to question 4.

|          | Age, if living. | Age, at death. | Details of condition / Cause of death. |
|----------|-----------------|----------------|--|
| Father   |                 |                |  |
| Mother   |                 |                |  |
| Siblings |                 |                |  |

5. Within the past 5 years, have you:
  - a) Had or been advised to have a diagnostic test (other than for HIV) such as an EKG, CAT scan, MRI scan, echocardiogram, angiogram, biopsy, or endoscopy?  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
  - c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?  Yes  No
6. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for:
  - a) High blood pressure, coronary artery disease, heart murmur, chest pain, irregular heart beat, aneurysm, stroke, Transient Ischemic Attack, circulatory surgery, a disease or disorder of the arteries or circulatory system or had a heart attack or heart surgery?  Yes  No
  - b) Anemia, high cholesterol, swollen glands or a disease or disorder of the blood or lymphatic system?  Yes  No
  - c) Cancer, tumor, polyp, cyst, melanoma, unexplained swelling or lump or a malignancy?  Yes  No
  - d) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, chronic cough, sleep apnea or a disease or disorder of the respiratory system?  Yes  No
  - e) Seizures, epilepsy, dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease or a disease or disorder of the brain or nervous system?  Yes  No
  - f) Anxiety, depression, bi-polar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder (PTSD) or a mental health disorder?  Yes  No
  - g) Blood or albumin in the urine or a disease or disorder of the prostate, bladder, kidney or genitor-urinary organs?  Yes  No
  - h) Diabetes, or a disease or disorder of the thyroid, pituitary, pancreas or endocrine system?  Yes  No
  - ii) Hepatitis, colitis, ileitis, gastritis, ulcer, Crohn's disease or a disease or disorder of the digestive system?  Yes  No
  - j) Arthritis, fibromyalgia, or a disease or disorder of the back, neck or musculoskeletal system?  Yes  No
  - k) Lupus or a disease or disorder of the immune system (other than HIV) or connective tissue?  Yes  No

**Additional Information** (Explain all "Yes" answers above)

| Question # | State diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone numbers. |
|------------|---|
|            |   |
|            |   |
|            |   |

I declare that I have read page 1 of this report and represent that the information provided, as shown in this report, is true, and is a complete disclosure of all information requested in this report. I understand and agree that this report is part of and subject to the Application. I also understand and agree that the information provided in this report will be relied upon as evidence of insurability that will influence the assessment and acceptance of the Application by Foresters.

Signature of proposed insured or parent/legal guardian, if the proposed insured is a juvenile. \_\_\_\_\_

Signed at (City, State) \_\_\_\_\_ Signed on (mmm/dd/yyyy) \_\_\_\_\_

Medical Examiner (please print) \_\_\_\_\_ Signature of Medical Examiner (as witness) \_\_\_\_\_

**Medical Examination Report** This examination should be made in private.

For purposes of this page of this form, 'you' refers to the person conducting the exam.

|       |        |     |        |  |                                  |                                  |                               |
|-------|--------|-----|--------|--|----------------------------------|----------------------------------|-------------------------------|
| 6. a) | Height |     | Weight |  | Males only:                      |                                  |                               |
|       | ft.    | in. | lbs.   |  | Chest (full inspiration).<br>in. | Chest (force expiration).<br>in. | Abdomen, at umbilicus.<br>in. |

b) Did you weigh the proposed insured?  Yes.  No.  
 Did you measure the proposed insured?  Yes.  No.

c) Is appearance unhealthy or older than stated age?  Yes.  No.

Details of 'Yes' answers. (Identify them.)

7. Blood pressure(record ALL readings)

|                                    |  |  |  |
|------------------------------------|--|--|--|
| Systolic                           |  |  |  |
| Diastolic - 4 <sup>th</sup> phase. |  |  |  |
| - 5 <sup>th</sup> phase.           |  |  |  |

8. Pulse

|                        |         |                |                 |
|------------------------|---------|----------------|-----------------|
| Rate                   | At Rest | After Exercise | 3 minutes later |
| Irregularities per min |         |                |                 |

9. Heart: Is there any:

|             |  |         |  |
|-------------|--|---------|--|
| Enlargement | <input type="radio"/> Yes. <input type="radio"/> No. | Dyspnea | <input type="radio"/> Yes. <input type="radio"/> No. |
| Murmur(s)   | <input type="radio"/> Yes. <input type="radio"/> No. | Edema   | <input type="radio"/> Yes. <input type="radio"/> No. |

(Describe below - if more than one, describe separately.)

|                  |                       |                       |  |                                     |
|------------------|-----------------------|-----------------------|--|-------------------------------------|
|                  | Murmur #1             | Murmur#2              |  | Mid-clavicular line                 |
| Location:        | <input type="text"/>  | <input type="text"/>  | Indicate:  |                                     |
| Constant         | <input type="radio"/> | <input type="radio"/> | Apex by X  | <p>Numbers Indicate interspaces</p> |
| Inconstant       | <input type="radio"/> | <input type="radio"/> | Murmur area by <input type="radio"/>                 |                                     |
| Transmitted      | <input type="radio"/> | <input type="radio"/> | Point of greatest Intensity by <input type="radio"/> |                                     |
| Localized        | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Systolic         | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Presystolic      | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Diastolic        | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Soft (Gr. 1 - 2) | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Mod (Gr. 3 - 4)  | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Loud (Gr. 5 - 6) | <input type="radio"/> | <input type="radio"/> |  |                                     |
| After Exercise:  |                       |                       | Transmission by →                                    |                                     |
| Increased        | <input type="radio"/> | <input type="radio"/> | For comments and Your impression                     |                                     |
| Absent           | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Unchanged        | <input type="radio"/> | <input type="radio"/> |  |                                     |
| Decreased        | <input type="radio"/> | <input type="radio"/> |  |                                     |

10. Is there on examination an abnormality of the following: (Circle applicable items and give details.)

|   |  |
|---|--|
| a) Eyes, ears, nose, mouth, pharynx.  | <input type="radio"/> Yes. <input type="radio"/> No. |
| (If vision or hearing markedly impaired, indicate degree and correction.)     |  |
| b) Skin (incl. scars), lymph nodes, varicose veins or peripheral arteries.    | <input type="radio"/> Yes. <input type="radio"/> No. |
| c) Nervous system (include reflexes, gait, paralysis).                        | <input type="radio"/> Yes. <input type="radio"/> No. |
| d) Respiratory system.  | <input type="radio"/> Yes. <input type="radio"/> No. |
| e) Abdomen (include scars).   | <input type="radio"/> Yes. <input type="radio"/> No. |
| f) Genitourinary system.  | <input type="radio"/> Yes. <input type="radio"/> No. |
| g) Endocrine system. (include thyroid and breasts).                           | <input type="radio"/> Yes. <input type="radio"/> No. |
| h) Musculoskeletal system. (include spine, joints, amputations, deformities). | <input type="radio"/> Yes. <input type="radio"/> No. |

11. Are there any hernias?  Yes.  No.

12. Are you aware of any additional medical history for this proposed insured?  
 (A confidential report may be sent to the Medical Director.)  Yes.  No.

13. Urinalysis:

|         |       |       |
|---------|-------|-------|
| Albumin | Sugar | Blood |
|         |       |       |

If history or presence of albumin, sugar, kidney disease or stone, blood pressure over 150/90, send specimen to: ExamOne 10101 Renner Blvd., Lenexa, KS 66219

Are you sending a specimen?  Yes.  No.

**When completed mail to:**  
 The Independent Order of Foresters  
 P.O. Box 179  
 Buffalo NY 14201-0179



## The Independent Order of Foresters ("Foresters")

### Activities of Daily Living Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. With whom do you reside? (e.g. parent, spouse, children, friend): \_\_\_\_\_  
 If you live alone, how long have you lived alone? \_\_\_\_\_
2. Do you work either part-time or full-time or perform volunteer work? \_\_\_\_\_
3. Do you currently drive a car? Yes  No   
 If, "No" did you ever drive and if so, why did you stop driving?: \_\_\_\_\_  
 \_\_\_\_\_

4. Have you ever experienced the following? (for each "Yes" answer, fill in columns below)

|                             | Yes                   | No                    | How often | Date of last experience |                 |
|-----------------------------|-----------------------|-----------------------|-----------|-------------------------|-----------------|
| a) Dizziness                | <input type="radio"/> | <input type="radio"/> | _____     | _____                   |                 |
| b) Falls                    | <input type="radio"/> | <input type="radio"/> | _____     | _____                   |                 |
| c) Fractures                | <input type="radio"/> | <input type="radio"/> | _____     | _____                   | Location: _____ |
| d) Unsteadiness of gait     | <input type="radio"/> | <input type="radio"/> | _____     | _____                   |                 |
| e) Memory lapses, confusion | <input type="radio"/> | <input type="radio"/> | _____     | _____                   |                 |
| f) Insomnia                 | <input type="radio"/> | <input type="radio"/> | _____     | _____                   |                 |

5. Do you exercise regularly? Yes  No   
 If, "Yes", please state each type of exercise, its duration and frequency: \_\_\_\_\_  
 \_\_\_\_\_

6. Any other additional comments related to your activities of daily living: \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Activities of Daily Living Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)





## The Independent Order of Foresters ("Foresters")

### Alcohol Usage Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Indicate your current alcohol consumption:

|        | Beer (quantity) | Wine (quantity) | Liquor (quantity) |
|--------|-----------------|-----------------|-------------------|
| Daily  |                 |                 |                   |
| Weekly |                 |                 |                   |

2. Have you ever consumed more alcohol than you do currently? Yes  No

If "Yes", when and why did you change your drinking habits? \_\_\_\_\_

3. Have you ever consulted a physician or received treatment or counseling, related to alcohol use? Yes  No

Yes  No

If "Yes", please provide details:

| Name of Physician, hospital or clinic | Address | Dates         |
|---------------------------------------|---------|---------------|
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |

4. Have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous or a similar support group for recovering addicts? Yes  No

If "Yes", please answer the following questions:

When? \_\_\_\_\_

Are you presently active? Yes  No

How often do you attend meetings? \_\_\_\_\_

How many meetings did you attend in the last six months? \_\_\_\_\_

Have you had any lapses of sobriety? Yes  No

If "Yes", please state relevant dates \_\_\_\_\_

5. Have you ever pled guilty to, or been convicted of, driving under the influence of alcohol, reckless driving, ever had your driver's license suspended or been required to attend an alcohol or drug awareness program ordered by the court? Yes  No

If "Yes", please provide details including dates for each occurrence: \_\_\_\_\_

6. Have you even taken time off work or have your working duties been affected or restricted in any way due to your use of alcohol?

Yes  No

If "Yes", please provide details including dates and durations. \_\_\_\_\_

7. Please provide any additional information that you feel is important in relation to your alcohol use: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I declare that I have read this Alcohol Usage Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Arrhythmia/Atrial Fibrillation/Irregular Heartbeat Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. When was this condition first diagnosed? Please attach a copy of any medical reports, if available \_\_\_\_\_  
Date (mmm/dd/yyyy)

2. Is the arrhythmia/atrial fibrillation/irregular heartbeat:
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> chronic (permanent)      | <input type="checkbox"/> premature supraventricular atrial beats (PAC's) | <input type="checkbox"/> bigeminy or trigeminy   |
| <input type="checkbox"/> proxysmal (intermittent) | <input type="checkbox"/> premature ventricular beats (PVC's)             | <input type="checkbox"/> ventricular tachycardia |
| <input type="checkbox"/> multifocal               |  |  |

3. Are there any symptom(s) with the arrhythmia/atrial fibrillation/irregular heartbeat?

- Black-out
- Dizziness (light-headedness)/faint feeling
- Palpitations
- Chest discomfort

4. Have any of the following tests been done for this condition? If so, please give date and results:

- |   |       |       |                    |
|---|-------|-------|--------------------|
| <input type="checkbox"/> ECG            | _____ | _____ | Date (mmm/dd/yyyy) |
| <input type="checkbox"/> Stress test    | _____ | _____ | Date (mmm/dd/yyyy) |
| <input type="checkbox"/> Echocardiogram | _____ | _____ | Date (mmm/dd/yyyy) |
| <input type="checkbox"/> Holter monitor | _____ | _____ | Date (mmm/dd/yyyy) |

5. Do you currently take medication(s) for this condition? Yes  No

If "Yes", please provide details:

| Name of medication(s) | Dose | Frequency |
|-----------------------|------|-----------|
|                       |      |           |
|                       |      |           |
|                       |      |           |
|                       |      |           |

6. Other than already stated, have you taken other medication(s) or been treated with surgery in the past for this condition? Yes  No

If "Yes", please provide details:

| Name of medication(s) or treatment(s) | Dose | Frequency | Date last taken |
|---------------------------------------|------|-----------|-----------------|
|                                       |      |           | (mmm/dd/yyyy)   |

7. The cause of the arrhythmia/atrial fibrillation/irregular heartbeat is due to:

- |  |   |  |                                  |
|--|---|--|----------------------------------|
| <input type="checkbox"/> coronary heart disease    | <input type="checkbox"/> alcohol        | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> unknown |
| <input type="checkbox"/> mitral valve disease      | <input type="checkbox"/> cardiomyopathy | <input type="checkbox"/> anxiety         |                                  |
| <input type="checkbox"/> other, give details _____ |   |  |                                  |

8. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen, or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Dates         |
|---------------------------------------|---------|-----------|---------------|
|                                       |         |           | (mmm/dd/yyyy) |

9. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details including dates and durations. \_\_\_\_\_

10. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

I declare that I have read this Arrhythmia/Atrial Fibrillation/Irregular Heartbeat Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Arthritis Questionnaire

|                                      |   |
|--------------------------------------|---|
| <b>Proposed Insured</b>              |   |
| First name _____                     | Middle name _____ Last name _____                         |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference number (if available)/certificate number: _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. What type of arthritis do you have?       Rheumatoid       Osteoarthritis       Other: \_\_\_\_\_
2. Severity:       Mild       Moderate       Severe
3. When was this first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)
4. Please describe your symptoms in relation to this condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. How often do symptoms occur? (i.e. how often in the last week, month, 12 months?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Joints affected: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. (a) Details of any deformity or limitation of movement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- (b) Do you use any aids, (e.g. canes, walkers, wheelchair) ? \_\_\_\_\_
8. Have you had an operation for arthritis or is an operation being considered? Yes  No
9. Do you currently take any medication for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

10. Other than already stated, have you taken other medication(s) or had other treatment(s) in the past for this condition? Yes  No
- If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

11. Have you had any test(s) or investigation(s) for this condition? (e.g. X-rays, CT scans, MRI?) Yes  No

If "Yes", please provide details:

| Name of test or investigation | Location | Date          | Result |
|-------------------------------|----------|---------------|--------|
|                               |          | (mmm/dd/yyyy) |        |
|                               |          | (mmm/dd/yyyy) |        |
|                               |          | (mmm/dd/yyyy) |        |

12. Please provide details regarding the physician(s) and/or medical practitioner(s) you have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

13. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No

If "Yes", please provide details including dates and durations. \_\_\_\_\_  
 \_\_\_\_\_

14. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
 \_\_\_\_\_

15. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Arthritis Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Attention-Deficit Hyperactivity Disorder (ADHD) or Attention-Deficit Disorder (ADD) Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference number/certificate (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured if no child is indicated, or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Age you were first diagnosed with ADHD or ADD \_\_\_\_\_
2. Please indicate all behavioral symptom(s):
 

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Short attention span, distracted easily | <input type="checkbox"/> Aggression, defiance           | <input type="checkbox"/> Risk taking behavior |
| <input type="checkbox"/> Accident prone, multiple injuries       | <input type="checkbox"/> Inattentive, careless mistakes | <input type="checkbox"/> Lying, truancy       |
| <input type="checkbox"/> Explosive irritability                  | <input type="checkbox"/> Co-ordination difficulty       | <input type="checkbox"/> Vandalism            |
| <input type="checkbox"/> Forgetfulness, impatience               | <input type="checkbox"/> Low self esteem                | <input type="checkbox"/> Stealing, cruelty    |
| <input type="checkbox"/> Impulsive, emotional changes            | <input type="checkbox"/> Learning difficulties          | <input type="checkbox"/> Trouble with the law |
3. Please list medical and physical problems related to this condition: \_\_\_\_\_  
 \_\_\_\_\_
4. Please list current medication(s) and dosage(s): \_\_\_\_\_  
 \_\_\_\_\_
5. Has the medication(s) been changed in the past 3 years? Yes  No   
 If "Yes", please list past medications and dosages: \_\_\_\_\_  
 \_\_\_\_\_
6. Is the medication required all year, or only during school/work? \_\_\_\_\_
7. Please provide details of past and current treatment(s) including duration(s): \_\_\_\_\_  
 \_\_\_\_\_
8. Current school grade (if applicable): \_\_\_\_\_
9. Past and current behavioral adjustment at school (if applicable): \_\_\_\_\_  
 \_\_\_\_\_
10. Past and current academic performance in school (if applicable): \_\_\_\_\_  
 \_\_\_\_\_
11. Please name other family members with ADHD and/or ADD: \_\_\_\_\_  
 \_\_\_\_\_
12. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

13. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Aviation Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Total of all hours flown as pilot?: \_\_\_\_\_  
 Total hours flown in last 12 months: \_\_\_\_\_  
 If 'None', date of last flight: \_\_\_\_\_  
 Estimated hours flying in the next 12 months: \_\_\_\_\_
2. Pilot certificate(s) currently held:
 

|   |   |  |
|---|---|--|
| <input type="radio"/> Student                       | <input type="radio"/> Flight Instructor | <input type="radio"/> Private                    |
| <input type="radio"/> Airline Transportation Rating | <input type="radio"/> Commercial        | <input type="radio"/> Instrumental Flight Rating |

 Issue Dates? \_\_\_\_\_
3. Type of current flying:
 

|                                    |                                |                                  |                                  |
|------------------------------------|--------------------------------|----------------------------------|----------------------------------|
| <input type="radio"/> Pleasure     | <input type="radio"/> Military | <input type="radio"/> Commercial | <input type="radio"/> Instructor |
| <input type="radio"/> Experimental | <input type="radio"/> Business | <input type="radio"/> Stunting   |                                  |

 Please describe the plane you are currently flying: \_\_\_\_\_
4. Do you contemplate any change in your flying activity? Yes  No   
 If "Yes", please explain: \_\_\_\_\_  
 \_\_\_\_\_
5. Are you a professional pilot or crew member flying for pay? Yes  No   
 If "Yes", describe aircraft and nature of flying (e.g. bush pilot, fire fighting, aerial application, air ambulance, cargo): \_\_\_\_\_  
 \_\_\_\_\_
6. Do you fly into any hazardous areas? Yes  No   
 If "Yes", please explain: \_\_\_\_\_  
 \_\_\_\_\_
7. Have you ever been involved in an aircraft accident? Yes  No   
 If "Yes", please explain: \_\_\_\_\_  
 \_\_\_\_\_
8. Where and by whom is your plane maintained? \_\_\_\_\_
9. Medical certificate currently held:  I  II  III
10. Have you ever failed an Aviation Medical Exam? Yes  No   
 If "Yes", please explain: \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Aviation Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Back & Neck Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference number/certificate (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the precise diagnosis or nature of the disorder (e.g. simple back strain, degenerative disk disease, herniated disk, lumbago, sciatica, spondylosis, spondyloarthopathy, whiplash etc.): \_\_\_\_\_  
\_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)
3. When did you first experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)
4. What was the underlying cause of this condition(e.g. accident, degeneration, recreational or sporting injury etc.)? \_\_\_\_\_  
\_\_\_\_\_
5. Please advise which part of your back is/was affected (e.g. cervical spine (neck), thoracic spine (upper middle) or lumbar spine (lower)) and describe your symptoms including details of any radiation down the arms or legs: \_\_\_\_\_  
\_\_\_\_\_
6. a) Are the symptoms ongoing? Yes  No   
 If "Yes", are the symptoms  decreasing  remaining stable  worsening in severity?  
 b) When did you last experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)  
 c) Please also advise how often or how many times you have ever experienced symptoms in relation to this condition and how long the symptoms persisted on these occasions? \_\_\_\_\_  
\_\_\_\_\_
7. Have your daily activities even been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

8. Do you currently take medication(s) for this condition? Yes  No   
 If "Yes", please provide details:

| Name of medication(s). | Dose. | Frequency. |
|------------------------|-------|------------|
|                        |       |            |
|                        |       |            |

9. Other than already stated, have you taken other medication(s) or had other treatment(s) in the past for this condition? Yes  No   
 If "Yes", please provide details:

| Name of medication(s) or treatment(s). | Dose. | Frequency. | Date last taken. |
|--|-------|------------|------------------|
|  |       |            | (mmm/dd/yyyy)    |
|  |       |            | (mmm/dd/yyyy)    |
|  |       |            | (mmm/dd/yyyy)    |

10. Please provide details of any other treatment that you have had for this condition, (e.g. surgery, treatment by a physiotherapist, chiropractor, osteopath, massage therapist, acupuncturist etc.):

| Type of treatment. | Name of practitioner or clinic. | Address. | Date of last consult. |
|--------------------|---------------------------------|----------|-----------------------|
|                    |                                 |          | (mmm/dd/yyyy)         |
|                    |                                 |          | (mmm/dd/yyyy)         |
|                    |                                 |          | (mmm/dd/yyyy)         |

11. Have you ever had any test(s) or investigation(s) carried out in relation to this condition, (e.g. x-ray, MRI, CT scan or nerve conduction studies)? Yes  No

If "Yes", please provide details including dates, procedures, locations and results:

| Name of test or investigation. | Address. | Date.         | Result. |
|--------------------------------|----------|---------------|---------|
|                                |          | (mmm/dd/yyyy) |         |
|                                |          | (mmm/dd/yyyy) |         |
|                                |          | (mmm/dd/yyyy) |         |

12. Have you ever been admitted to a hospital for this condition? Yes  No

If "Yes", please provide details including dates, procedures, locations and results: \_\_\_\_\_

13. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_

14. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic, | Address. | Date of last consult. |
|--|----------|-----------------------|
|  |          | (mmm/dd/yyyy)         |
|  |          | (mmm/dd/yyyy)         |
|  |          | (mmm/dd/yyyy)         |

15. Have you ever taken time off work or have your working duties ever been affected or restricted in any way (e.g. restricted ability to drive, lift, carry objects, bend or sit for prolonged periods) in relation to this condition? Yes  No

If "Yes", please provide details including dates and durations: \_\_\_\_\_

16. Have you ever experienced any anxiety or depression in relation to this condition? Yes  No

If "Yes", please provide details including dates and durations: \_\_\_\_\_

17. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

I declare that I have read this Back & Neck Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Benign Prostate Questionnaire

(Benign Prostate Hypertrophy and Prostatitis)

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Date of first diagnosis: \_\_\_\_\_  
Date (mmm/dd/yyyy)

2. If any of the following tests have been done for this condition, please give details and result(s):

| Test                               | Date          | Result(s) |
|------------------------------------|---------------|-----------|
| Bladder catheterization            | (mmm/dd/yyyy) |           |
| Prostate biopsy                    | (mmm/dd/yyyy) |           |
| Prostate ultrasound                | (mmm/dd/yyyy) |           |
| TURP (transurethral prostatectomy) | (mmm/dd/yyyy) |           |

3. Do you currently take medication(s) for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

4. Other than already stated, have you taken other medication(s) or had any other treatment(s) in the past for this condition? Yes  No

If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

5. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

6. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

7. Have you ever taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No

If "Yes", please provide details including dates and durations: \_\_\_\_\_  
\_\_\_\_\_

8. Please provide any additional information that you feel is important in relation to this condition and attach a copy of any medical reports if available: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this Benign Prostate Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Business Financial Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "Application" means the Application for Individual Life Insurance on the proposed insured.

Please provide the following information:

Business name and brief description of type of business.

- Type of business:       Corporation                       Partnership                       Proprietorship
- Give below the full names and titles of Owners, Partners or Officers. (Where space is insufficient, use a separate piece of paper which must be signed and dated.):

| Full Name | Title | Age | % Ownership | Active in Business                                 |
|-----------|-------|-----|-------------|--|
|           |       |     |             | Yes <input type="radio"/> No <input type="radio"/> |
|           |       |     |             | Yes <input type="radio"/> No <input type="radio"/> |
|           |       |     |             | Yes <input type="radio"/> No <input type="radio"/> |

- Date business started: \_\_\_\_\_  
(mmm/dd/yyyy)
- Recent reorganization/recapitalization of business in the past years? Yes  No

|   |                 |  |                 |
|---|-----------------|--|-----------------|
| <b>Non Fixed Assets:</b>  | <b>Dollars:</b> | <b>Current &amp; Short Term Liabilities:</b>       | <b>Dollars:</b> |
| Currents Assets:  | _____           | Current Liabilities:                               | _____           |
| Non Fixed Cash:   | _____           | Accounts Payable:                                  | _____           |
| Accounts Receivable:  | _____           | Notes payable:                                     | _____           |
| Inventories:  | _____           | Accrued Interest Payable:                          | _____           |
| Other (specify):  | _____           | Federal Income Tax Payable:                        | _____           |
|   | _____           | Other (specify):                                   | _____           |
|   | _____           |  | _____           |
| <b>Total Non Fixed Assets:</b>  | <b>\$</b> _____ | <b>Total Current &amp; Short Term Liabilities:</b> | <b>\$</b> _____ |
| <b>Net worth (total non fixed assets minus total current &amp; short term liabilities):</b> |                 | <b>\$</b> _____                                    |                 |

|  |                 |                                     |                 |
|--|-----------------|-------------------------------------|-----------------|
| <b>Fixed Assets:</b>   | <b>Dollars:</b> | <b>Long Term Liabilities:</b>       | <b>Dollars:</b> |
| Land:  | _____           | First Mortgage Bonds:               | _____           |
| Building(s):   | _____           | Other (specify):                    | _____           |
| Machinery:   | _____           | Note(s):                            | _____           |
| Office Equipment:  | _____           |                                     | _____           |
| Other (specify):   | _____           |                                     | _____           |
|  | _____           |                                     | _____           |
|  | _____           |                                     | _____           |
| <b>Total Fixed Assets:</b>   | <b>\$</b> _____ | <b>Total Long Term Liabilities:</b> | <b>\$</b> _____ |
| <b>Net worth (total fixed assets minus total long term liabilities):</b> |                 | <b>\$</b> _____                     |                 |

**Income:**

Net Annual Sales: \$ \_\_\_\_\_  
Net Annual Income after deducting operating expense and taxes: \$ \_\_\_\_\_  
Variation in earnings versus previous year:  Increase  Decrease  Same

I declare that I have read this questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Climbing and Mountaineering Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

- How many years have you been climbing? \_\_\_\_\_
- How often do you climb? \_\_\_\_\_
- Are you a member of a club? Yes  No
- Nature of climbing-please give details of:
  - Type of terrain (e.g. rock, snow/ice, artificial climbing walls): \_\_\_\_\_  
\_\_\_\_\_
  - Degree of difficulty e.g. easy, moderate, difficult, severe: \_\_\_\_\_  
\_\_\_\_\_

If severe, please indicate maximum technical grade (4a, 4b----7b, 7c): \_\_\_\_\_

  - Maximum height climbed to: \_\_\_\_\_
  - Season of the year in the climbing location when you climb? \_\_\_\_\_
- What proportion of your climbing is on routes protected by climbing bolts? \_\_\_\_\_
- Do you ever climb alone or without a rope? Yes  No   
If "Yes", please state how often, location and degree of difficulty: \_\_\_\_\_  
\_\_\_\_\_
- Do you plan to go on any climbing and/or mountaineering expeditions in the next 2 years? Yes  No   
If "Yes", please give full details, including area, length of expedition and frequency of trips: \_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this Climbing and Mountaineering Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Chest Pain Questionnaire

|                                      |   |
|--------------------------------------|---|
| <b>Proposed Insured</b>              |   |
| First name _____                     | Middle name _____ Last name _____                   |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference /certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the precise diagnosis if known (e.g. angina, costochondritis, esophageal reflux, muscle strain, myocardial infarction, palpitations, stress, etc.). Attach a copy of any medical report(s) if available. \_\_\_\_\_  
\_\_\_\_\_
2. When did you first experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)
3. Please describe these symptoms fully. \_\_\_\_\_  
\_\_\_\_\_
4. How long did the symptoms last? \_\_\_\_\_
5. Have you had any recurrence of symptoms? Yes  No   
If "Yes", please provide details including frequency, duration, and the approximate date of the last episode: \_\_\_\_\_  
\_\_\_\_\_
6. Were your symptoms associated with exercise, exertion, excitement, food, infection, strain, other? Yes  No   
If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_
7. Please provide details of any test(s) or investigation(s) that you have undergone in relation to this condition, (e.g. blood tests, chest x-rays, coronary angiogram, echocardiograph, electrocardiograph, endoscopy, exercise stress test etc.).

| Name of test or investigation | Location | Date          | Results |
|-------------------------------|----------|---------------|---------|
|                               |          | (mmm/dd/yyyy) |         |
|                               |          | (mmm/dd/yyyy) |         |
|                               |          | (mmm/dd/yyyy) |         |

8. Do you currently take medication for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

9. Other than already stated, have you taken other medication in the past for this condition? Yes  No

If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

10. Other than already stated, have you ever been admitted to a hospital or had out-patient treatment for this condition? Yes  No   
 If "Yes", please provide details:

| Details of treatment | Name of physician, hospital or clinic | Dates         |
|----------------------|---------------------------------------|---------------|
|                      |                                       | (mmm/dd/yyyy) |
|                      |                                       | (mmm/dd/yyyy) |
|                      |                                       | (mmm/dd/yyyy) |

11. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

12. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
 \_\_\_\_\_

13. Have you ever taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details including dates and durations: \_\_\_\_\_

\_\_\_\_\_

14. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Chest Pain Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Diabetes Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured, if no child is indicated or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the diagnosis relevant to you, (e.g. Type I or Type II Diabetes Mellitus, Gestational Diabetes, Impaired Glucose Tolerance or Impaired Fasting Glucose etc.). Attach a copy of any medical reports if available. \_\_\_\_\_

2. When was this condition first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)

3. When did you first experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)

4. Do you test your own blood sugar at home? Yes  No

If "Yes", please provide details for the last 3 months:

| Frequency of testing | Lowest result | Highest result | Average result |
|----------------------|---------------|----------------|----------------|
|                      |               |                |                |

5. Have you had a glycosylated haemoglobin test (HbA1c)? Yes  No

If "Yes", please provide details including the approximate date and result of your most recent test: \_\_\_\_\_

6. Please provide details of the medication(s) that you take in relation to this condition (please also include related medication(s) such as those used to lower blood pressure and/or cholesterol):

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

7. Have you ever been admitted to a hospital or required emergency care in relation to this condition? Yes  No

If "Yes", please provide details:

| Reason | Name of physician, hospital or clinic | Address | Dates         |
|--------|---------------------------------------|---------|---------------|
|        |                                       |         | (mmm/dd/yyyy) |
|        |                                       |         | (mmm/dd/yyyy) |

8. Related to this condition, have you ever had:
- i) Eye problems? Yes  No
  - ii) Heart problems? Yes  No
  - iii) High blood pressure? Yes  No
  - iv) Kidney problems (including protein in your urine)? Yes  No
  - v) Sensory problems (such as burning in your feet)? Yes  No
  - vi) Any other complication (i.e. diabetic coma)? Yes  No

If you answered "Yes" to any of the above questions, please provide details: \_\_\_\_\_  
 \_\_\_\_\_

9. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

10. Other than for the purpose of regular checks, has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No
- If "Yes", please provide details: \_\_\_\_\_  
 \_\_\_\_\_

11. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No
- If "Yes", please provide details including dates and durations. \_\_\_\_\_  
 \_\_\_\_\_

12. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Diabetes Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Cyst, Lump, Tumor Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. When was the cyst, lump or tumor first discovered? \_\_\_\_\_
2. In which part of your body was the cyst, lump or tumor located? \_\_\_\_\_
3. Please state the precise diagnosis, if known and attach any medical reports if available. \_\_\_\_\_

4. Has the cyst, lump or tumor been removed? Yes  No

If "No", please provide:

- a) Details of the test(s) and the investigation(s) which have been carried out. Include date(s) and result(s) of test(s). \_\_\_\_\_
- b) Details of proposed treatment or surgery. \_\_\_\_\_

If "Yes", please provide:

- a) Date of removal: \_\_\_\_\_
- b) Method of removal, (e.g. local anesthetic, cryosurgery, operation with general anesthetic, in doctor's office, outpatient, etc. \_\_\_\_\_

c) Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

- d) What treatment have you had following removal? For example, tablets, radiotherapy, chemotherapy etc. \_\_\_\_\_
- e) Have you been given information regarding the outlook or prognosis? Yes  No  If "Yes", please provide details. \_\_\_\_\_

5. Are you still being followed-up with by a physician and or medical practitioner in relation to this condition? Yes  No

If "Yes", please provide details:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

If "No", when were you discharged from follow-up? \_\_\_\_\_

6. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
If "Yes", please provide details including dates and durations. \_\_\_\_\_

\_\_\_\_\_

7. Please provide any additional information about your condition, treatment or follow-up which you feel is important: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I declare that I have read this Cyst, Lump or Tumor Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Digestive System Disorders Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference number/certificate (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured if no child is indicated, or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the precise diagnosis or nature of the condition you are suffering from (e.g. ulcerative proctitis or Crohn's disease etc.) and attach a copy of any medical reports, if available. \_\_\_\_\_
2. When was this condition diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)
3. When did you first experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)
4. Please describe the symptom(s) related to this condition: \_\_\_\_\_
5. How often do you typically experience symptoms related to this condition? \_\_\_/week \_\_\_/month \_\_\_/year
6. Is the frequency of symptoms related to this condition becoming:       more frequent     less frequent     unchanged
7. Are you aware of anything that precipitates your symptoms? Yes  No   
If "Yes", please provide details: \_\_\_\_\_

8. When did you last experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)

9. Do you currently take medication(s) for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication(s) | Dose | Frequency |
|-----------------------|------|-----------|
|                       |      |           |
|                       |      |           |
|                       |      |           |

10. Other than already stated, have you taken other medication(s) or had other treatment(s) including surgery in the past for this condition?  
Yes  No   
If "Yes", please provide details:

| Name of medication(s) or treatment(s) | Dose | Frequency | Date last taken |
|---------------------------------------|------|-----------|-----------------|
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |

11. Have you ever had test(s) or investigation(s) for this condition e.g. colonoscopy etc.? Yes  No   
If "Yes", please provide details:

| Name of test(s) or investigation(s) | Location | Date          | Result |
|-------------------------------------|----------|---------------|--------|
|                                     |          | (mmm/dd/yyyy) |        |
|                                     |          | (mmm/dd/yyyy) |        |
|                                     |          | (mmm/dd/yyyy) |        |

12. Have you ever been admitted to a hospital for this condition? Yes  No

If "Yes", please provide details:

| Name of physician, hospital or clinic | Address | Dates         |
|---------------------------------------|---------|---------------|
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |

13. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

14. Have you ever had other extraintestinal complications (e.g. eye problems, skin problems, gallbladder problems, urinary problems or arthritis) in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

15. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

16. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No

If "Yes", please provide details including dates and durations. \_\_\_\_\_  
\_\_\_\_\_

17. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Drug and Substance Usage Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please indicate which of the following substances you have ever tried or used:

- i) Alcohol (if "Yes", a separate Alcohol Usage Questionnaire may be required) \_\_\_\_\_ Yes  No
- ii) Amphetamines (speed, uppers, dexies, crystal meth, ice etc.) \_\_\_\_\_ Yes  No
- iii) Anabolic steroids (roids, gear, juice etc.) \_\_\_\_\_ Yes  No
- iv) Barbiturates (amytal, Phenobarbital etc.) \_\_\_\_\_ Yes  No
- v) Cannabis (marijuana, dope, hooch, grass, pot, hashish, THC etc.) \_\_\_\_\_ Yes  No
- vi) Cocaine (coke, blow, snow, crack etc.) \_\_\_\_\_ Yes  No
- vii) Ecstasy (meth amphetamine, MDMA, ecky, E's etc.) \_\_\_\_\_ Yes  No
- viii) Opiates (codeine, heroin, methadone, morphine, pethidine, smack etc.) \_\_\_\_\_ Yes  No
- ix) Psychedelics (magic mushrooms, LSD, acid etc.) \_\_\_\_\_ Yes  No
- x) Solvents (glue, aerosol, thinners, nitrous oxide, petrol etc.) \_\_\_\_\_ Yes  No
- xi) Others: \_\_\_\_\_ Yes  No

If you answered "Yes" to any of the above questions, please provide details regarding your usage pattern:

| Name of Substance | Date first used | Date ceased   | Frequency of use |
|-------------------|-----------------|---------------|------------------|
|                   | (mmm/dd/yyyy)   | (mmm/dd/yyyy) |                  |

2. Have you ever injected or used intravenously drugs that were not prescribed by a licensed physician? Yes  No

If "Yes", please provide details including dates: \_\_\_\_\_  
\_\_\_\_\_

3. Have you ever tested positive for Hepatitis B or C? Yes  No

If "Yes", please provide details including dates and results: \_\_\_\_\_  
\_\_\_\_\_

4. Have you ever sought medical advice or been referred to drug counseling? Yes  No

If "Yes" please provide details:

| Name of Physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

5. Have you ever been hospitalized or treated for a drug overdose? Yes  No

| Name of Physician, hospital or clinic | Address | Date          |
|---------------------------------------|---------|---------------|
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |

6. Have you ever suffered any medical condition or impairment related to your drug use, e.g. hepatitis, HIV, mental health disorder etc.? Yes  No   
 If "Yes", please provide details including dates and results: \_\_\_\_\_  
 \_\_\_\_\_
7. Have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous or a similar association? Yes  No   
 If "Yes", please answer the following questions:  
 When? \_\_\_\_\_  
 Are you presently active? \_\_\_\_\_  
 How often do you attend meetings? \_\_\_\_\_  
 How many meetings did you attend in the last six months? \_\_\_\_\_  
 Have you had any lapses? Yes  No   
 If "Yes", please state relevant dates: \_\_\_\_\_
8. Have you ever pled guilty to, or been convicted of, any alcohol or drug related offence or been required to attend an alcohol or drug awareness program ordered by the court? Yes  No   
 If "Yes", please provide details including dates for each occurrence: \_\_\_\_\_  
 \_\_\_\_\_
9. Have you even taken time off work or have your working duties been affected or restricted in any way due to your alcohol and/or drug use? Yes  No   
 If "Yes", please provide details including dates and durations. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
10. Please provide any additional information that you feel is important in relation to your alcohol or drug use: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Drug and Substance Usage Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Epilepsy and Seizure Disorder Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference number/certificate (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured, if no child is indicated, or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the precise diagnosis or nature of the condition you are suffering from (e.g. absence seizures (petit mal), atonic seizures (drop attacks), myoclonic seizures, tonic clonic seizures (grand mal), simple partial seizures, complex seizures (psychomotor)). Attach a copy of any medical reports if available. \_\_\_\_\_

2. When was this condition first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)

3. When did you first experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)

4. Please describe your seizures: \_\_\_\_\_

5. How often do you typically experience a seizure? \_\_\_\_\_/week \_\_\_\_\_/month \_\_\_\_\_/year

6. Is the frequency of seizures becoming:       more frequent     less frequent     unchanged

7. Are you aware of anything that precipitates your symptoms? Yes  No   
If "Yes", please provide details: \_\_\_\_\_

8. When was your last seizure? \_\_\_\_\_  
Date (mmm/dd/yyyy)

9. Do you currently take medication(s) for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication(s) | Dose | Frequency |
|-----------------------|------|-----------|
|                       |      |           |
|                       |      |           |
|                       |      |           |

10. Other than already stated, have you taken other medication(s) or had other treatment(s) in the past for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication(s) or treatment(s) | Dose | Frequency | Date last taken |
|---------------------------------------|------|-----------|-----------------|
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |

11. Have you ever had test(s) or investigation(s) (e.g. electroencephalogram (EEG), CT scan, MRI scan, other etc.), in relation to this condition? Yes  No   
If "Yes", please provide details:

| Name of test(s) or investigation(s) | Location | Date          | Result |
|-------------------------------------|----------|---------------|--------|
|                                     |          | (mmm/dd/yyyy) |        |
|                                     |          | (mmm/dd/yyyy) |        |
|                                     |          | (mmm/dd/yyyy) |        |

12. Have you ever been admitted to a hospital for this condition? Yes  No

If "Yes", please provide details:

| Name of physician, hospital or clinic | Address | Frequency | Dates         |
|---------------------------------------|---------|-----------|---------------|
|                                       |         |           | (mmm/dd/yyyy) |
|                                       |         |           | (mmm/dd/yyyy) |
|                                       |         |           | (mmm/dd/yyyy) |

13. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
 \_\_\_\_\_

14. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

15. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details including dates and durations. \_\_\_\_\_  
 \_\_\_\_\_

16. Are you permitted to drive a motor vehicle? Yes  No

17. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Epilepsy and Seizure Disorder Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Foreign Travel Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

Please provide full details to the following questions:

1. Birthplace: \_\_\_\_\_ Citizenship: \_\_\_\_\_
2. If not a U.S. citizen, what is your status in the United States? \_\_\_\_\_ SSN \_\_\_\_\_
3. Country of Permanent Residence: \_\_\_\_\_ How long? \_\_\_\_\_
4. What is your occupation/duties? \_\_\_\_\_
5. Please list each city and country to which you have traveled in the past two years, the length of stay in each location and the specific date of the travel.

| City and Country | Where do you stay (hotel, family, etc.) | Length of stay | Date | Purpose of travel |
|------------------|---|----------------|------|-------------------|
|                  |   |                |      |                   |
|                  |   |                |      |                   |
|                  |   |                |      |                   |

6. List each city and country to which you will be traveling in the next 2 years, the length of stay in each location, the specific date of the travel and how many times per year you visit each location.

| City and Country | Where do you stay (hotel, family, etc.) | Length of stay | Date | # times per year | Purpose of travel |
|------------------|---|----------------|------|------------------|-------------------|
|                  |   |                |      |                  |                   |
|                  |   |                |      |                  |                   |
|                  |   |                |      |                  |                   |

7. Anticipated date of permanent return to country of permanent residence: \_\_\_\_\_
8. Are you on any medication(s) which you will continue while traveling? \_\_\_\_\_
5. Other comments: \_\_\_\_\_

I declare that I have read this Foreign Travel Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Heart Murmur Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured if no child is indicated, or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. What type of murmur do you have? Please attach a copy of any medical reports, if available.
- |   |  |  |
|---|--|--|
| <input type="radio"/> Aortic stenosis   | <input type="radio"/> Aortic regurgitation | <input type="radio"/> Aortic insufficiency |
| <input type="radio"/> Mitral stenosis   | <input type="radio"/> Mitral regurgitation | <input type="radio"/> Mitral insufficiency |
| <input type="radio"/> Pulmonic stenosis | <input type="radio"/> Flow murmur          | <input type="radio"/> Innocent murmur      |

2. When was the heart murmur first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)

3. Do you have a history of rheumatic fever? Yes  No

4. When were you last seen by a physician for the heart murmur? \_\_\_\_\_  
Date (mmm/dd/yyyy)

5. When was the last echocardiogram done for the heart murmur? \_\_\_\_\_  
Date (mmm/dd/yyyy)

Results? \_\_\_\_\_

6. Was a cardiac catheterization ever done for this condition? Yes  No

If "Yes", please provide date and results: \_\_\_\_\_

7. Do you currently take medication(s) for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |
|                    |      |           |

8. Other than already stated above, have you taken other medication(s) in the past for this condition? Yes  No

If "Yes", please provide details:

| Name of medication(s) or treatment(s) | Dose | Frequency | Date last taken              |
|---------------------------------------|------|-----------|------------------------------|
|                                       |      |           | <small>(mmm/dd/yyyy)</small> |

9. Do you have any symptoms or any limitation of activities due to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_

10. Have you had any heart surgery or has surgery been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_

11. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen, or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Dates         |
|---------------------------------------|---------|-----------|---------------|
|                                       |         |           | (mmm/dd/yyyy) |
|                                       |         |           | (mmm/dd/yyyy) |
|                                       |         |           | (mmm/dd/yyyy) |

12. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details including dates and durations. \_\_\_\_\_

13. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

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I declare that I have read this Heart Murmur Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### High Blood Pressure Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. When were you first diagnosed with high blood pressure? \_\_\_\_\_  
Date (mmm/dd/yyyy)
2. Why was your blood pressure measured at that particular time? E.g. routine examination, due to symptoms etc.? \_\_\_\_\_  
\_\_\_\_\_
3. Do you know what your blood pressure readings were at diagnosis? Yes  No   
If "Yes", please provide details: \_\_\_\_\_
4. Have you had an EKG, X-ray, blood lipid or other test investigation(s) in relation to this condition? Yes  No   
If "Yes", please provide details of the result, including date(s) of the test(s) and investigation(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you currently take medication(s) for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

6. Other than already stated, have you taken other medication(s) in the past for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

7. Please provide details regarding the doctor(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of doctor, hospital or clinic | Address | Frequency | Date of last consult |
|------------------------------------|---------|-----------|----------------------|
|                                    |         |           | (mmm/dd/yyyy)        |
|                                    |         |           | (mmm/dd/yyyy)        |
|                                    |         |           | (mmm/dd/yyyy)        |

8. Have any abnormalities (e.g. protein, blood, etc.) even been found in your urine? Yes  No   
If "Yes", please provide date(s) and full details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do you smoke cigarettes, cigars or a pipe? Yes  No   
 If "Yes", please specify type and how many a day?: \_\_\_\_\_
10. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details including dates and durations. \_\_\_\_\_  
 \_\_\_\_\_
11. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this High Blood Pressure Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Kidney and Urinary Disorders Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference number/certificate (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured if no child is indicated, or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the precise diagnosis, if known and attach a copy of any medical reports if available. \_\_\_\_\_
2. When was this condition first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)
3. Have you had an intravenous pyelogram (IVP), cystoscopy or other test(s) or investigation(s) in relation to this condition? Yes  No   
If "Yes", please provide details of the results including date(s) of the test(s) and the investigation(s): \_\_\_\_\_
4. Regarding your symptom(s) in relation to this condition:
  - a) Please describe your symptom(s). \_\_\_\_\_
  - b) When did the symptom(s) first occur? \_\_\_\_\_
  - c) How frequently do the symptom(s) occur? (i.e. how often in the last 12 months?) \_\_\_\_\_
  - d) When was the last occurrence of the symptom(s)? \_\_\_\_\_
5. Have you had an operation for this condition or is an operation being considered? Yes  No  If "Yes",
  - a) Please provide date(s) and full details including names of the hospital and consultant, physician/surgeon. \_\_\_\_\_
  - b) Have you experienced any symptom(s) following surgery? Yes  No  If "Yes", please provide details. \_\_\_\_\_

6. Do you currently take medication(s) for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |

7. Other than already stated, have you taken other medication(s) or had other treatment in the past for this condition? Yes  No   
If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

8. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

9. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
If "Yes", please provide details including dates and durations. \_\_\_\_\_

\_\_\_\_\_

10. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I declare that I have read this Kidney and Urinary Disorders Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Lupus Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. What is the type of lupus diagnosed?
  - Systemic lupus erythematosus (SLE)
  - Discoid lupus
  - Drug-induced SLE
2. When was the condition first diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)
3. Please note if the lupus is:
  - In remission (list date of last exacerbation): \_\_\_\_\_ Date (mmm/dd/yyyy)
  - Currently present/active
4. Have you had any of the following symptoms in relation to this condition?
  - Low blood counts
  - Heart involvement
  - Renal insufficiency or failure
  - Neurologic disorder
  - Proteinuria
  - High blood pressure
  - Lung involvement (pleuritis)
5. Do you currently take medication(s) for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

6. Other than already stated above, have you taken other medication(s) in the past for this condition e.g. steroids? Yes  No
- If "Yes", please provide details:

| Name of medication(s) or treatment(s) | Dose | Frequency | Date last taken |
|---------------------------------------|------|-----------|-----------------|
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |

7. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

8. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen, or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Dates         |
|---------------------------------------|---------|-----------|---------------|
|                                       |         |           | (mmm/dd/yyyy) |
|                                       |         |           | (mmm/dd/yyyy) |
|                                       |         |           | (mmm/dd/yyyy) |

9. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
If "Yes", please provide details including dates and durations. \_\_\_\_\_

\_\_\_\_\_

10. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I declare that I have read this Lupus Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Mental Health Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please indicate which of the mental health condition(s) you have/had:
 

|  |  |
|--|--|
| a) Anxiety including generalized anxiety, panic or phobia disorder | Yes <input type="radio"/> No <input type="radio"/> |
| b) Eating disorder including anorexia nervosa or bulimia           | Yes <input type="radio"/> No <input type="radio"/> |
| c) Depression including major depression or dysthymia              | Yes <input type="radio"/> No <input type="radio"/> |
| d) Bipolar disorder or manic depressive illness                    | Yes <input type="radio"/> No <input type="radio"/> |
| e) Alcohol or other substance abuse or addiction                   | Yes <input type="radio"/> No <input type="radio"/> |
| f) Post-traumatic stress   | Yes <input type="radio"/> No <input type="radio"/> |
| g) Schizophrenia or any other psychotic disorder                   | Yes <input type="radio"/> No <input type="radio"/> |
| h) Stress, sleeplessness, chronic tiredness                        | Yes <input type="radio"/> No <input type="radio"/> |
| i) Other (please describe):  | Yes <input type="radio"/> No <input type="radio"/> |

2. Please describe your symptoms relating to this condition:

| Symptoms | Date from     | Date to       |
|----------|---------------|---------------|
|          | (mmm/dd/yyyy) | (mmm/dd/yyyy) |

3. Has any reason for your condition been identified? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
 \_\_\_\_\_

4. When was the condition first diagnosed? \_\_\_\_\_  
 Date (mmm/dd/yyyy)

5. When did you first experience symptoms? \_\_\_\_\_  
 Date (mmm/dd/yyyy)

6. Have you had any recurrence of this condition(s)? Yes  No

If "Yes", please provide details:

| Date from     | Date to       |
|---------------|---------------|
| (mmm/dd/yyyy) | (mmm/dd/yyyy) |
| (mmm/dd/yyyy) | (mmm/dd/yyyy) |
| (mmm/dd/yyyy) | (mmm/dd/yyyy) |

7. Do you currently take medication(s) for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

8. Other than already stated above, have you taken other medication(s) in the past for this condition? Yes  No

If "Yes", please provide details:

| Name of medication(s) or treatment(s) | Dose | Frequency | Date last taken |
|---------------------------------------|------|-----------|-----------------|
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |
|                                       |      |           | (mmm/dd/yyyy)   |

9. Have you ever had any other treatment(s) for this condition e.g. counseling, cognitive behavioral therapy, electroconvulsive treatment etc.?

Yes  No

If "Yes", please provide details:

| Nature of treatment | Location | Date          |
|---------------------|----------|---------------|
|                     |          | (mmm/dd/yyyy) |
|                     |          | (mmm/dd/yyyy) |
|                     |          | (mmm/dd/yyyy) |

10. Have you ever been admitted to a hospital or clinic for this condition? Yes  No

If "Yes", please provide details:

| Name of physician, hospital or clinic | Address | Date(s)       |
|---------------------------------------|---------|---------------|
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |

11. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
 \_\_\_\_\_

12. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen, or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Dates         |
|---------------------------------------|---------|---------------|
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |

13. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No

If "Yes", please provide details including dates and durations. \_\_\_\_\_  
 \_\_\_\_\_

14. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Mental Health Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)





# The Independent Order of Foresters ("Foresters")

## Personal Financial Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "Application" means the Application for Individual Life Insurance on the proposed insured.

Please provide the following information (current as of this date).

| Assets:   | Dollars | Current & short term Liabilities                   | Dollars |
|---|---------|--|---------|
| Cash on hand & in Banks:  | _____   | Mortgages:   | _____   |
| Stocks, bonds, funds:   | _____   | Accounts payable:                                  | _____   |
| Real estate:  | _____   | Notes payable:                                     | _____   |
| Car(s):   | _____   | Loans:   | _____   |
| Business equity:  | _____   | Other liabilities:                                 | _____   |
| Other (specify):  | _____   |  | _____   |
|   | _____   |  | _____   |
| <b>Total assets:</b>  | _____   | <b>Total current &amp; short term liabilities:</b> | _____   |
| <b>Net worth</b> (total assets minus total current & short term liabilities): |         | _____  |         |

| Earned income (annual):                                       | Dollars | Expenses (annual)      | Dollars |
|---|---------|------------------------|---------|
| Salary & wages:   | _____   | Mortgage(s):           | _____   |
| Bonus:  | _____   | Rent(s):               | _____   |
| Commission:   | _____   | Note(s):               | _____   |
| Other (specify):  | _____   | Estimated taxes:       | _____   |
|   | _____   | Insurance premiums:    | _____   |
|   | _____   | Living expenses:       | _____   |
|   | _____   | Other (specify):       | _____   |
|   | _____   |                        | _____   |
| <b>Total earned income:</b>                                   | _____   | <b>Total expenses:</b> | _____   |
| <b>Net income</b> (total earned income minus total expenses): |         | _____                  |         |

| Unearned income (annual):     | Dollars |
|-------------------------------|---------|
| Net rentals:                  | _____   |
| Dividends:                    | _____   |
| Interest:                     | _____   |
| Investments:                  | _____   |
| Pensions:                     | _____   |
| Other (specify):              | _____   |
|                               | _____   |
| <b>Total unearned income:</b> | _____   |

I declare that I have read this questionnaire. I represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Prostate Cancer Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Date of diagnosis and please attach any medical reports if available: \_\_\_\_\_  
Date (mmm/dd/yyyy)
2. What was the pretreatment Prostate Specific Antigen (PSA) result? \_\_\_\_\_
3. How was the cancer treated?  
 Observation only  
 TURP (transurethral prostatectomy)  
 Radical prostatectomy  
 Hormone therapy
4. What was the date and result of the most current PSA test? \_\_\_\_\_
5. What was the Gleason score? \_\_\_\_\_
6. What stage was the cancer? \_\_\_\_\_
7. Is there a family history of cancer? \_\_\_\_\_
8. Do you currently take medication(s) for this condition? Yes  No   
 If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

9. Other than already stated, have you taken other medication(s) or had any other treatment(s) in the past for this condition? Yes  No   
 If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

10. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Frequency | Date of last consult |
|---------------------------------------|---------|-----------|----------------------|
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |
|                                       |         |           | (mmm/dd/yyyy)        |

11. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
 If "Yes", please provide details including dates and durations. \_\_\_\_\_

12. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this Prostate Cancer Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Respiratory Disorders Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| <b>Proposed Insured</b>              |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |
| Child's Name _____                   |  |                 |

Note – "You" and "your" mean the proposed insured, if no child is indicated or the child if a child is indicated. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Please state the precise diagnosis or nature of the condition you are suffering from (e.g. asthma, bronchitis, COPD, emphysema, shortness of breath etc.) and attach any medical reports if available. \_\_\_\_\_  
\_\_\_\_\_
2. When was the condition diagnosed? \_\_\_\_\_  
Date (mmm/dd/yyyy)
3. When did you first experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)
4. Please describe your symptoms. \_\_\_\_\_
5. How often do you typically experience symptoms related to this condition? \_\_\_/day \_\_\_/week \_\_\_/month \_\_\_/year
6. How long do the symptoms usually last? \_\_\_\_\_
7. Are your symptoms precipitated by seasonal changes, exercise, respiratory infections etc.? Yes  No   
If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

8. When did you last experience symptoms in relation to this condition? \_\_\_\_\_  
Date (mmm/dd/yyyy)

9. Do you currently take medication(s) for this condition? Yes  No

If "Yes", please provide details:

| Name of medication | Dose | Frequency |
|--------------------|------|-----------|
|                    |      |           |
|                    |      |           |
|                    |      |           |

10. Other than already stated, have you taken other medication(s) in the past for this condition or been treated with oral steroids or oxygen therapy? Yes  No

If "Yes", please provide details:

| Name of medication or treatment | Dose | Frequency | Date last taken |
|---------------------------------|------|-----------|-----------------|
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |
|                                 |      |           | (mmm/dd/yyyy)   |

11. Have you ever had any test(s) or investigation(s) carried out in connection to this condition (e.g. pulmonary function tests/spirometry, peak flow, chest x-ray etc.)? Yes  No

If "Yes", please provide details and attach copies of any medical reports if available:

| Name of test or investigation | Location | Date          | Results |
|-------------------------------|----------|---------------|---------|
|                               |          | (mmm/dd/yyyy) |         |
|                               |          | (mmm/dd/yyyy) |         |
|                               |          | (mmm/dd/yyyy) |         |

12. Have you ever been treated in Emergency, admitted to hospital or had out-patient follow-up for this condition? Yes  No

If "Yes", please provide details:

| Name of physician, hospital or clinic | Address | Dates         |
|---------------------------------------|---------|---------------|
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |
|                                       |         | (mmm/dd/yyyy) |

13. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes  No

If "Yes", please provide details: \_\_\_\_\_

14. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

15. Have you even taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No

If "Yes", please provide details including dates and durations. \_\_\_\_\_

16. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I declare that I have read this Respiratory Disorders Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
 Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
 Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
 (City, State)

Signed on \_\_\_\_\_  
 Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Scuba and Skin Diving Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. In the past 10 years, have you done any:
  - a) Scuba diving? Yes  No
  - b) Skin diving? Yes  No
2. If you have been scuba diving or skin diving please complete the following:

| Depth of dives             | Total number of dives | Number of dives in last 12 months | Number of dives in next 12 months |
|----------------------------|-----------------------|-----------------------------------|-----------------------------------|
| 50' or less                |                       |                                   |                                   |
| 51'-75'                    |                       |                                   |                                   |
| 76'-100'                   |                       |                                   |                                   |
| 101'-150'                  |                       |                                   |                                   |
| If over 150' state maximum |                       |                                   |                                   |

3. Please describe the equipment used: \_\_\_\_\_
4. What is the purpose of your diving? \_\_\_\_\_
5. What are the locations of your diving (e.g. cave, under ice, ocean, inland waters etc.)? \_\_\_\_\_
6. Do you do any professional diving? Yes  No   
If "Yes", state details: \_\_\_\_\_
7. Are you a member of a club or organization? Yes  No
8. Do you ever dive alone? Yes  No
9. Do you intend to change your rate of participation? Yes  No   
If "Yes", state details: \_\_\_\_\_
10. Additional information: \_\_\_\_\_

I declare that I have read this Scuba and Skin Diving Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Sleep Apnea/Sleep Disorder Questionnaire

|                                      |  |                 |
|--------------------------------------|--|-----------------|
| Proposed Insured                     |  |                 |
| First name _____                     | Middle name _____                                  | Last name _____ |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |                 |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

**ALL CLIENTS MUST ANSWER QUESTIONS #1-3, WHETHER OR NOT #1 IS YES OR NO**

1. Have you ever been diagnosed with a sleep disorder? Yes  No
- If "Yes", identify:  Sleep apnea  Narcolepsy  Insomnia  Other (specify) \_\_\_\_\_
- Date of onset: \_\_\_\_\_
- Symptoms at the time of diagnosis: \_\_\_\_\_

What is the severity of your sleep disorder?  Mild  Moderate  Severe

Do you have any related depression or anxiety? (*complete a Mental Health Questionnaire if "Yes"*) Yes  No

2. Have you had any sleep studies, test(s) or other investigation(s) for a diagnosed disorder or have they been ordered due to a suspected sleep disorder? Yes  No

If "Yes", please provide details:

| Test/Investigation | Date          | Result |
|--------------------|---------------|--------|
|                    | (mmm/dd/yyyy) |        |
|                    | (mmm/dd/yyyy) |        |
|                    | (mmm/dd/yyyy) |        |

3. Do you receive or have you received any treatment or have any treatments been recommended for a sleep disorder, including medication(s) and/or devices? Yes  No

If "Yes", please provide details:

| Treatment, device or medication | Date prescribed | Prescribed dosage or frequency of use | Date last used |
|---------------------------------|-----------------|---------------------------------------|----------------|
|                                 | (mmm/dd/yyyy)   |                                       | (mmm/dd/yyyy)  |
|                                 | (mmm/dd/yyyy)   |                                       | (mmm/dd/yyyy)  |
|                                 | (mmm/dd/yyyy)   |                                       | (mmm/dd/yyyy)  |

Has treatment  improved  eliminated  not changed your symptoms?  unknown

4. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

| Name of physician, hospital or clinic | Address | Date of last consult |
|---------------------------------------|---------|----------------------|
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |
|                                       |         | (mmm/dd/yyyy)        |

5. Have you ever taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes  No   
If "Yes", please provide details including dates and durations: \_\_\_\_\_

\_\_\_\_\_

6. Please provide any additional information that you feel is important in relation to this condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I declare that I have read this Sleep Apnea/Sleep Disorder Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



## The Independent Order of Foresters ("Foresters")

### Tobacco Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. Do you use tobacco? Yes  No   
(Including cigarettes, chewing tobacco, cigars, nicotine patch, nicotine gum, snuff, marijuana)  
If "Yes", what type(s) and how often? \_\_\_\_\_  
\_\_\_\_\_
2. Have you ever used tobacco? Yes  No   
If "Yes", please give date tobacco was last used: \_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this Tobacco Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)



# The Independent Order of Foresters ("Foresters")

## Hazardous Sports Questionnaire

|                                      |  |
|--------------------------------------|--|
| <b>Proposed Insured</b>              |  |
| First name _____                     | Middle name _____ Last name _____                  |
| Date of Birth _____<br>(mmm/dd/yyyy) | Reference/certificate number (if available): _____ |

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

Please answer the following questions concerning any participation in a hazardous sport.

1. Type of sport: \_\_\_\_\_
2. Do you participate as a(n):
  - a) Amateur? Yes  No
  - b) Professional? Yes  No
3. Total number of times you have participated in this sport: \_\_\_\_\_
4. Date you last participated in this sport: \_\_\_\_\_  
(mmm/dd/yyyy)
5. Do you intent to participate in the future? Yes  No   
If "Yes" please state number in the next 12 months: \_\_\_\_\_
6. PLEASE COMPLETE THE FOLLOWING AS APPLICABLE TO YOUR SPORT:
  - a) Specific class or event: \_\_\_\_\_
  - b) Describe equipment or machine used (including fuel, engine size, if appropriate) \_\_\_\_\_  
\_\_\_\_\_
  - c) Top speed attainable: \_\_\_\_\_
  - d) What is the average length of the event (In feet, miles, laps or time as appropriate): \_\_\_\_\_
  - e) What is the longest distance you have attained (depth, height, etc.) \_\_\_\_\_
7. Are you affiliated with a club? Yes  No
8. Do you intend to change your participation? Yes  No
9. Additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that I have read this Hazardous Sports Questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at \_\_\_\_\_  
(City, State)

Signed on \_\_\_\_\_  
Date (mmm/dd/yyyy)

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
Project Name/Number: /

## Supporting Document Schedules

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Flesch Certification<br><b>Comments:</b><br><b>Attachment:</b><br>Readability Certification.pdf |              |              |

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Bypassed - Item:</b> Application<br><b>Bypass Reason:</b> The Application for Individual Life Insurance is attached under the Form Schedule tab for approval.<br><b>Comments:</b> |              |              |

|   | Item Status: | Status Date: |
|---|--------------|--------------|
| <b>Satisfied - Item:</b> Notices<br><b>Comments:</b><br>This form discusses MIB information and privacy rights.<br>Please see Filing Description under General Information tab for details.<br><b>Attachment:</b><br>770627 US 0210 Notices.pdf |              |              |

|   | Item Status: | Status Date: |
|---|--------------|--------------|
| <b>Satisfied - Item:</b> Highlighted version of Application<br>770630 US 02/10<br><b>Comments:</b><br><b>Attachment:</b><br>770630 US 0210 App HL.pdf |              |              |

**The Independent Order of Foresters**

NAME OF COMPANY: The Independent Order of Foresters  
Forester House, 789 Don Mills Road, Toronto, Ontario M3C 1T9  
(416) 429-3000

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**A. Option Selected**

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is below.  
 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below.

Form and Form Numbers to which Certification is Applicable:

**See attached Page.**

**B. Test Option Selected**

1. Test was applied to entire policy form(s).  
 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

**C. Standards for Certification**

**A checked block indicates the standard has been achieved.**

1. The policy text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.
2. It is printed in not less than 10-point type, one point leaded. (This does not apply to specification pages, schedules and tables).
3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
4. The section titles are captured in bold-faced type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages).

This certification must be signed by an officer of the insurer.

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Steve Lintner  
Director, Product Solutions

March 25, 2010

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Date

Form and Form Numbers to which Certification is Applicable

| Form Name  | Form Number     | Flesch Score |
|--|-----------------|--------------|
| Activities of Daily Living Questionnaire   | 101468 US 02/10 | 53.3         |
| Aerial Sports Questionnaires   | 104030 US 02/10 | 50.6         |
| Alcohol Usage Questionnaire  | 105056 US 02/10 | 52.0         |
| Arrhythmia/Atrial Fibrillation/ Irregular Heartbeat Questionnaire                    | 105057 US 02/10 | 52.5         |
| Arthritis Questionnaire  | 101459 US 02/10 | 50.7         |
| Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder Questionnaire | 101461 US 02/10 | 50.4         |
| Aviation Questionnaire   | 104357 US 02/10 | 50.5         |
| Back & Neck Questionnaire  | 105058 US 02/10 | 52.9         |
| Benign Prostate Questionnaire  | 105059 US 02/10 | 50.8         |
| Business Financial Questionnaire   | 101463 US 02/10 | 50.0         |
| Climbing and Mountaineering Questionnaire  | 104024 US 02/10 | 55.5         |
| Chest Pain Questionnaire   | 105060 US 02/10 | 50.0         |
| Diabetes Questionnaires  | 105065 US 02/10 | 50.8         |
| Cyst, Lumps or Tumor Questionnaire   | 104019 US 02/10 | 56.0         |
| Digestive System Disorders Questionnaire   | 105073 US 02/10 | 50.2         |
| Drug and Substance Usage Questionnaire   | 105066 US 02/10 | 51.4         |
| Epilepsy and Seizure Disorder Questionnaire  | 105068 US 02/10 | 50.2         |
| Foreign Travel Questionnaire   | 104628 US 02/10 | 52.8         |
| Heart Murmur Questionnaire   | 105071 US 02/10 | 51.0         |
| High Blood Pressure Questionnaire  | 104020 US 02/10 | 52.3         |
| Kidney and Urinary Disorders Questionnaire   | 104021 US 02/10 | 50.6         |
| Lupus Questionnaire  | 105077 US 02/10 | 50.5         |
| Mental Health Questionnaire  | 105079 US 02/10 | 50.5         |
| Military Questionnaire   | 101472 US 02/10 | 53.2         |
| Personal Financial Questionnaire   | 101467 US 02/10 | 50.1         |
| Prostate Cancer Questionnaire  | 105085 US 02/10 | 51.1         |
| Respiratory Disorders Questionnaire  | 105086 US 02/10 | 51.2         |
| Scuba and Skin Diving Questionnaire  | 104033 US 02/10 | 53.4         |
| Sleep Apnea/Sleep Disorder Questionnaire   | 105089 US 02/10 | 51.5         |
| Tobacco Questionnaire  | 101470 US 02/10 | 54.9         |
| Hazardous Sports Questionnaire   | 104031 US 02/10 | 50.6         |
| Medical Examination Report   | 104977 US 02/10 | 54.0         |
| Contingent Owner/Other Payer Identification Form                                     | 104907 US 02/10 | 55.3         |

Form and Form Numbers to which Certification is Applicable  
Combined Flesch Score

| Form Name  | Form Number     | Flesch Score |
|--|-----------------|--------------|
| Product Details Page – Lifefirst Term Life         | 770148 US 02/10 | 50.0         |
| Product Details Page – Strong Foundation Term Life | 770331 US 02/10 |              |
| Product Details Page – Armor Universal Life        | 770270 US 02/10 |              |
| Product Details Page – BIG Universal Life          | 770524 US 02/10 |              |
| Product Details Page – SMART Universal Life        | 770598 US 02/10 |              |
| Application for Individual Life Insurance          | 770630 US 02/10 |              |

**Notices (This page must be given to the proposed insured.)**

For purposes of this Notice the following words and phrases are defined. The word "Application" means a Foresters application for insurance. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters. "You" and "Your" mean individually the proposed insured, and each child, if any, identified in the Application. If you have questions, discuss them with the producer who signed your application or contact us directly. Write to Foresters, Chief Underwriter 789 Don Mills Road Toronto, Canada M3C 1T9, or to our US Mailing Address at PO Box 179 Buffalo, NY 14201-0179.

**Privacy** -Personal information we obtain about you is confidential. As permitted by privacy laws, we may disclose information without further authorization to consumer reporting agencies hired to prepare consumer reports or consumer investigative reports, insurance companies to which you have applied for coverage or benefits, our reinsurers, those providing services for us including insurance producers and agencies contracted or appointed by us and those conducting bona fide actuarial, marketing or scientific studies or audits and the respective employees, agents, contractors and consultants of each of the aforementioned. We may also disclose information to your physician and The Medical Information Bureau ('MIB, Inc.'). You can make a written request to review personal information about you in our file. However, we will not disclose information to you that was prepared for an anticipated claim, civil or criminal proceeding. You may request correction of information which you believe to be inaccurate or irrelevant. Upon written request, we will provide more information about these procedures.

**Medical and Personal Information** -The Underwriting process evaluates information about you to see if you qualify for the requested insurance. Answers in the Application are our principal source of information. We may contact other sources, such as a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, we may ask an independent agency to prepare a consumer report or an investigative consumer report about you. These reports may include information on your character and general reputation. They may also include personal characteristics, such as health, prescription history, finances, job and mode of living. The Federal Fair Credit Reporting Act gives you the right to make a written request, within a reasonable period of time, to receive additional information from Foresters about the nature and scope of an investigation. We will provide the contact information of any agency we ask to prepare such a report. You may contact the agency to learn about the contents or request a copy of the report. You may request a personal interview with the agency and they will make a reasonable attempt to talk to you. It will include that information in its report. If we order a report, it may include information obtained through interviews with your neighbors, friends or others you know. No adverse underwriting decision will be made based upon an individual's implied or confirmed sexual orientation or an individual's concern about or consultation for AIDS information.

**The Medical Information Bureau (MIB, Inc.)** -Information regarding your insurability will be treated as confidential. Foresters or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or at [www.mib.com](http://www.mib.com). Foresters, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## The Independent Order of Foresters ("Foresters")

### Application for Individual Life Insurance

| Proposed Insured   |  |  |  |  |
|--|--|--|--|--|
| First name:  | Middle name:   | Last name:   |  | <input type="radio"/> Male<br><input type="radio"/> Female |
| Street address (cannot be a P.O. Box.):  |  | City:  | State:   | Zip:   |
| Home phone #:  | Alternate phone # / Cell #:  | Best time to call:   | Date of birth (mmm/dd/yyyy):   | State & Country of birth:                                  |
| Social Security #:   | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |  | Primary language:<br><input type="radio"/> English <input type="radio"/> Spanish |  |
| Type of Photo I.D. (used to verify identity):<br><input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government ID: _____ |  |  |  |  |
| Photo I.D. # _____   |  |  |  |  |
| Occupation & duties:   |  | <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Seasonal |  |  |
| Hours worked per week (past 6 months): _____   |  | <input type="radio"/> Income (past 12 months): \$ _____  |  |  |
| Number of weeks worked in the past 12 months: _____  |  | <input type="radio"/> Net worth: \$ _____  |  |  |
| Foresters member?<br><input type="radio"/> Yes <input type="radio"/> No, applying for membership.  |  | Email address (optional):  |  |  |

### Beneficiary Information (Each beneficiary below is revocable. If, however, a beneficiary is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary.)

| Name of each primary beneficiary    | Relationship to proposed insured | % Share         |
|-------------------------------------|----------------------------------|-----------------|
|                                     |                                  | total           |
|                                     |                                  | must equal      |
|                                     |                                  | 100%            |
| Name of each contingent beneficiary | Relationship to proposed insured | % Share         |
|                                     |                                  | total           |
|                                     |                                  | must equal 100% |

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

|  |                              |  |             |
|--|------------------------------|--|-------------|
| Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust: |                              | Social Security # / Tax I.D. #:  |             |
| Street address (cannot be a P.O. Box.):  |                              | City:  | State: Zip: |
| Relationship to the proposed insured:  |                              | Email address (optional):  |             |
| Phone #:   | If Trust, name of Trustee:   | If Trust, date of Trust agreement:   |             |
| If Individual  |                              |  |             |
| <input type="radio"/> Male<br><input type="radio"/> Female                                     | Date of birth (mmm/dd/yyyy): | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |             |

**Other Insurance**

1. Is there another **annuity or** life insurance application pending for the proposed insured with Foresters or another insurer?  Yes  No

2. Does the proposed insured currently have **an annuity of** life, accidental death, critical illness or disability income insurance pending or in force?  Yes  No

If "Yes", to either question 1 or 2, complete the chart below. Also include information about Foresters life insurance **or** **annuity** certificate(s).

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| Name of Insurer | <b>Annuity/Life</b><br>insurance \$ | Accidental<br>death \$ | Critical illness<br>\$ | Disability income<br>(per month) \$ | Issue year or indicate if<br>pending |
|-----------------|-------------------------------------|------------------------|------------------------|-------------------------------------|--------------------------------------|
|                 |                                     |                        |                        |                                     |                                      |
|                 |                                     |                        |                        |                                     |                                      |

3. Has the proposed insured ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date \_\_\_\_\_ and reason \_\_\_\_\_  Yes  No

4. 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

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. Check the State requirements as these would need to be satisfied before the certificate can be issued. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those completed within the past 13 months.

For purposes of this Application, "diagnosed," "advised" and "treatment" mean by a licensed physician or medical practitioner.

**Children's Questions (Complete only if applying for Children's Term Coverage.)**

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

5. Has a child listed above:

a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease?  Yes  No

b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for Human Immunodeficiency Virus (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 5a or 5b, complete the chart below.

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

**Financial Questions**

6. Is there an intention, or an arrangement, that all or part of the insurance applied for will be:

a) Paid for by borrowing, financing or receiving money or any other property?  Yes  No

b) Transferred, assigned, sold or pledged?  Yes  No

If "Yes", to either question 6a or 6b provide details. \_\_\_\_\_

\_\_\_\_\_

7. Has the proposed insured, owner or a beneficiary arranged, been offered, or received, an inducement, fee or compensation to buy, or pay for, the insurance applied for? If "Yes", provide details. \_\_\_\_\_  Yes  No

\_\_\_\_\_

For each "Yes" answer in the Lifestyle and Medical Questions sections additional information may be required. Completing the corresponding questionnaire or, if no corresponding questionnaire is available, providing details in the Additional Information section may help speed up the Underwriting process.

| <b>Lifestyle Questions (For these questions "You" and "Your" mean the proposed insured.)</b>   |  |
|--|--|
| 8. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify:<br>Type used: _____ Date last used: _____<br>If currently smoking, how many pack(s) per day? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 9. Do you currently drink alcohol? If "Yes", specify:<br>How many times per week? _____ How many drinks per occasion? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 10. Within the past 10 years have you:<br>a) Used marijuana, heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or a controlled substance except as prescribed by a licensed physician or medical practitioner?<br>b) Received or been advised to receive treatment or counseling, by a licensed physician or medical practitioner, to discontinue or reduce the use of alcohol, non-prescribed or prescribed drugs? | <input type="radio"/> Yes <input type="radio"/> No<br><input type="radio"/> Yes <input type="radio"/> No |
| 11. Do you expect to travel outside of North America or change your country of residence within the next 2 years?  | <input type="radio"/> Yes <input type="radio"/> No   |
| 12. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 13. Have you, within the past 2 years, flown, or do you in the future intend to fly, in an aircraft as a student pilot, licensed pilot or crew member?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 14. Have you, within the past 2 years, engaged, or do you in the future intend to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 15. Have you ever had your driver's license suspended or revoked or within the past 5 years had more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____<br>_____   | <input type="radio"/> Yes <input type="radio"/> No   |
| 16. Within the past 10 years have you:<br>a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", provide date, details and State where each conviction occurred. _____<br>_____<br>b) Been convicted of, pled guilty to, or are you currently on probation or incarcerated for, a felony? If "Yes", provide date(s) and reason(s). _____<br>_____                                | <input type="radio"/> Yes <input type="radio"/> No<br><input type="radio"/> Yes <input type="radio"/> No |

| <b>Medical Questions (For these questions "You" and "Your" mean the proposed insured. For each "Yes" answer, provide details in the Additional Information section.)</b>   |  |
|--|--|
| 17.<br>a) Your: Height: _____ Weight: _____<br>b) Have you had a weight change of 10 pounds or more, within the past 12 months? If "Yes", specify: <input type="radio"/> Gain <input type="radio"/> Loss<br>How many pounds? _____ Reason: _____ | <input type="radio"/> Yes <input type="radio"/> No |
| 18. Date you last consulted a physician: _____<br>Physician Name: _____ Address: _____<br>a) Reason(s): _____<br>b) Were results of that consultation within normal ranges? If "No," provide details. _____<br>_____                             | <input type="radio"/> Yes <input type="radio"/> No |



## Payment Information and Authorization

The planned premium quoted may change following underwriting review.

|   |  |   |                                |
|---|--|---|--------------------------------|
| <b>Payer is:</b>  |  |   |                                |
| <input type="radio"/> Proposed insured  | <input type="radio"/> Owner (if other than proposed insured) | <input type="radio"/> Other (complete Contingent Owner/Other Payer Form)  |                                |
| <b>First premium payment to be made by:</b>   |  |   |                                |
| <input type="radio"/> Draft via Pre-Authorized Check (PAC) <input type="radio"/> Check (payable to Foresters) |  |   |                                |
| <b>Subsequent premium payments made by:</b>   |  |   |                                |
| <input type="radio"/> PAC <input type="radio"/> Direct Bill   |  |   |                                |
| <b>Payment mode:</b>  |  |   |                                |
| <input type="radio"/> Monthly (PAC only)  | <input type="radio"/> Quarterly                              | <input type="radio"/> Semi-annually                                       | <input type="radio"/> Annually |
| <b>PAC banking information (including drafting first premium) to be taken from:</b>                           |  |   |                                |
| <input type="radio"/> Attached void check   | <input type="radio"/> Check submitted with this Application  | <input type="radio"/> Information completed below (if no check available) |                                |
| Type of account: <input type="radio"/> Checking <input type="radio"/> Savings                                 |  |   |                                |
| Name of financial institution: _____  |  |   |                                |
| Street address: _____   |  |   |                                |
| City: _____ State: _____ Zip: _____   |  |   |                                |
| Transit #: _____ Account #: _____   |  |   |                                |

### 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 and agrees that: 1) Foresters is authorized to draft deductions under the PAC plan from that account or another account later identified or substituted by the payer. 2) The financial institution from which payments 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, if any, will be made and the amount of that deduction for the product issued. 4) This PAC plan 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 agreement must be signed by the bank account owner as his/her name appears on bank records for the account provided.

X \_\_\_\_\_  
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.



**Temporary Life Insurance Agreement (TIA) (Complete and leave with the owner only if all pre-conditions are met.)**

**Definitions** - "Application" means the Application for Individual Life Insurance of which this Agreement forms a part. "Producer" means the person who signed the Application as the producer. "Proposed Insured" and "Owner" mean the person(s) identified as such in the Application.

**Pre-Conditions to Temporary Coverage** - Subject to the terms of this Agreement, Foresters agrees to provide the temporary coverage set out in this Agreement, effective on the date the Application is signed by the owner, if each of the following pre-conditions are met: 1) The proposed insured is not age 71 or older on that date. 2) No more than \$1,000,000 insurance coverage on the life of the proposed insured is applied for in the Application, calculated by including the amount of the benefit applied for under each rider (except common carrier accidental death coverage if any) that is payable in the event of death of the proposed insured. 3) Each of the Temporary Life Insurance Agreement questions are answered 'No' and the 'No' answers shown are truthful and 4) No later than the date the Application is signed by the owner, first payment, at least equal to a monthly premium quoted for the insurance applied for in the Application, is provided or authorized. If one or more of the above pre-conditions are not met, no temporary coverage takes effect even if this Agreement was left with the owner.

**Temporary Life Insurance Agreement Questions**

|   |  |
|---|--|
| 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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

**Amount of Temporary Coverage** - Subject to the terms of this Agreement, if all of the above pre-conditions are met and the proposed insured dies while this Agreement is in effect, Foresters shall pay, to the beneficiary(ies), as shown in the Application, under this and all other Foresters temporary life insurance agreement(s) insuring the life of the proposed insured, the lesser of a) \$500,000; or, b) the amount of insurance applied for in the Application on the life of the deceased proposed insured, including the amount payable for the death of the proposed insured under a rider applied for (except common carrier accidental death coverage if any).

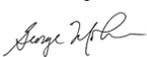
**Termination of Temporary Coverage** - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate on the life of the proposed insured takes effect as described in that certificate, if a certificate is issued in response to the Application. 3) The date Foresters offers, as shown in Foresters records, the owner a Foresters certificate in response to, but not as applied for in, the Application. 4) The date a written or oral request to withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 5) The date written notice is sent by Foresters, as shown in Foresters records, to the proposed insured or the owner, terminating this Agreement or declining the Application.

**Special Limitations** - This Agreement shall be void if the first payment, regardless of method, is not honored when presented for payment. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Foresters liability to a refund of payment(s) made to Foresters. If the proposed insured dies by suicide, whether sane or insane, Foresters liability under this Agreement is limited to a refund of the payment(s) made to Foresters.

**Entire Agreement and Governing Law** - This Agreement contains the entire terms regarding temporary coverage. No one, including the producer, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement. This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

**Acknowledgement** - I, the proposed insured and owner, if other than the proposed insured, by signing in the Signature Section of the Application, acknowledge and agree that I have reviewed, understand and accept the terms of this Temporary Life Insurance Agreement.

Countersigned,



George Mohacsi, President & Chief Executive Officer

**Authorization To Obtain And Disclose Information**

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims and c) supporting the operations of our business. In this authorization, "proposed insured" means the proposed insured identified in this Application. "Child" means every child named, if any, and proposed for insurance, in this Application. 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, authorizes Foresters, its reinsurers and those who perform services for Foresters related to an application for insurance or a claim for benefits, to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; other insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or Medical Information Bureau, Inc ('MIB, Inc.'). 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. Foresters may make a brief report to MIB, Inc. about the proposed insured and each child. Foresters or its authorized representatives may disclose information to: its reinsurers; appointed producers, agencies and those who perform services for Foresters related to an application for insurance or a claim for benefits; or those companies to which the proposed insured has applied or may apply to for life or health insurance, or benefits. Disclosure may be made when required or permitted by law and the disclosed information may no longer be protected by federal privacy laws. This authorization shall be the consent required, whether implied or express, written or oral, by applicable law(s), including Federal and state legislation and regulations regarding the collection, retention, usage and disclosure of information about or related to the proposed insured, owner and each child. This authorization is valid for two years from the date of this Application. Foresters or its authorized representatives may use an original document or a copy of this authorization to obtain information. This authorization may be revoked at any time by written notice to Foresters, except that action(s) taken before written revocation will not be affected. A Notices page has been provided to the proposed insured. It includes the MIB, Inc. and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

**Signature Section (For purposes of entire Application.)**

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of owner (if other than proposed insured)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile and the owner is not a parent/guardian)

Each person signed at: \_\_\_\_\_  
(City, State)

Each person signed on: \_\_\_\_\_  
Date (mmm/dd/yyyy)

**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 that might affect insurability; b) I personally met with the proposed insured and each child and asked the proposed insured and/or the owner each question as written in this Application to which an answer is shown, recorded those answers given to me by the proposed insured and owner, reviewed with each this Application before it was signed by that person, reviewed the document(s) used to verify identity and birth date and witnessed each signature in this Application; c) This Application has not been altered in any way after the proposed insured and owner signed it; d) 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; e) If applicable, I have disclosed that this Application may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission; f) 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.

Will the certificate applied for be a replacement for or change existing insurance or an annuity?  
Are you related to the proposed insured?

Yes  No  
 Yes  No

\_\_\_\_\_  
Producer's full name

\_\_\_\_\_  
Producer #

X \_\_\_\_\_  
Signature of producer

\_\_\_\_\_  
Date (mmm/dd/yyyy)

SERFF Tracking Number: FRSS-126516328 State: Arkansas  
 Filing Company: The Independent Order of Foresters State Tracking Number: 45258  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 2010 Life Application,UL, Underwriting Questionnaires, Paramed  
 Project Name/Number: /

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name                          | Replacement Creation Date | Attached Document(s)                  |
|----------------|----------|---|---------------------------|---------------------------------------|
| 03/24/2010     | Form     | Application for Individual Life Insurance   | 06/03/2010                | 770630 US 0210 App.pdf (Superseded)   |
| 03/24/2010     | Form     | Product Details Page - BIG Universal        | 04/07/2010                | 770524 US 0210 BIG.pdf (Superseded)   |
| 03/24/2010     | Form     | Product Details Page - SMART Universal Life | 04/07/2010                | 770598 US 0210 SMART.pdf (Superseded) |
| 03/24/2010     | Form     | Product Details Page - Armor Universal      | 04/07/2010                | 770270 US 0210 Armor.pdf (Superseded) |

## The Independent Order of Foresters ("Foresters")

### Application for Individual Life Insurance

| Proposed Insured   |  |  |  |                           |
|--|--|--|--|---------------------------|
| First name:  | Middle name:   | Last name:   | <input type="radio"/> Male<br><input type="radio"/> Female                       |                           |
| Street address (cannot be a P.O. Box.):  |  | City:  | State:   | Zip:                      |
| Home phone #:  | Alternate phone # / Cell #:  | Best time to call:   | Date of birth (mmm/dd/yyyy):   | State & Country of birth: |
| Social Security #:   | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |  | Primary language:<br><input type="radio"/> English <input type="radio"/> Spanish |                           |
| Type of Photo I.D. (used to verify identity):<br><input type="radio"/> Driver's license State: _____ <input type="radio"/> Passport <input type="radio"/> Other government ID: _____<br>Photo I.D. # _____ |  |  |  |                           |
| Occupation & duties:   |  | <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Seasonal |  |                           |
| Hours worked per week (past 6 months): _____   |  | <input type="radio"/> Income (past 12 months): \$ _____  |  |                           |
| Number of weeks worked in the past 12 months: _____  |  | <input type="radio"/> Net worth: \$ _____  |  |                           |
| Foresters member?<br><input type="radio"/> Yes <input type="radio"/> No, applying for membership.  |  | Email address (optional):  |  |                           |

### Beneficiary Information (Each beneficiary below is revocable. If, however, a beneficiary is to be irrevocable, insert the word "irrevocable" next to the name of that beneficiary.)

| Name of each primary beneficiary    | Relationship to proposed insured | % Share         |
|-------------------------------------|----------------------------------|-----------------|
|                                     |                                  | total           |
|                                     |                                  | must equal      |
|                                     |                                  | 100%            |
| Name of each contingent beneficiary | Relationship to proposed insured | % Share         |
|                                     |                                  | total           |
|                                     |                                  | must equal 100% |

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

|  |                              |  |             |
|--|------------------------------|--|-------------|
| Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust: |                              | Social Security # / Tax I.D. #:  |             |
| Street address (cannot be a P.O. Box.):  |                              | City:  | State: Zip: |
| Relationship to the proposed insured:  |                              | Email address (optional):  |             |
| Phone #:   | If Trust, name of Trustee:   | If Trust, date of Trust agreement:   |             |
| If Individual  |                              |  |             |
| <input type="radio"/> Male<br><input type="radio"/> Female                                     | Date of birth (mmm/dd/yyyy): | U.S. citizen?<br><input type="radio"/> Yes <input type="radio"/> No. If No, immigration status / type of Visa: _____ |             |

## Other Insurance

|   |                   |                     |                     |                                  |  |
|---|-------------------|---------------------|---------------------|----------------------------------|--|
| 1. Is there another life insurance application pending for the proposed insured with Foresters or another insurer?  |                   |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 2. Does the proposed insured currently have life, accidental death, critical illness or disability income insurance pending or in force?<br>If "Yes", to either question 1 or 2, complete the chart below. Also include information about Foresters life insurance certificate(s).  |                   |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| Name of Insurer   | Life insurance \$ | Accidental death \$ | Critical illness \$ | Disability income (per month) \$ | Issue year or indicate if pending                  |
|   |                   |                     |                     |                                  |  |
|   |                   |                     |                     |                                  |  |
| 3. Has the proposed insured ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date _____ and reason _____   |                   |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 4. 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)?   |                   |                     |                     |                                  | <input type="radio"/> Yes <input type="radio"/> No |
| 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. Check the State requirements as these would need to be satisfied before the certificate can be issued. Include existing life insurance or annuities that will be, or are in the process of being, lapsed or surrendered, and those completed within the past 13 months. |                   |                     |                     |                                  |  |

For purposes of this Application, "diagnosed," "advised" and "treatment" mean by a licensed physician or medical practitioner.

## Children's Questions (Complete only if applying for Children's Term Coverage.)

| Name of child (First, Middle, Last) under 18 years old<br>(must be a child of the proposed insured)   | Gender<br>(M or F) | Date of birth<br>(mmm/dd/yyyy)                   | Height<br>(ft/in)                     | Weight<br>(lbs) | Amount of coverage<br>in force   |
|---|--------------------|--|---------------------------------------|-----------------|--|
|   |                    |  |                                       |                 |  |
|   |                    |  |                                       |                 |  |
| 5. Has a child listed above:<br>a) Been diagnosed with, received treatment or medication for, or been placed under observation for, a disorder or disease?<br>b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for Human Immunodeficiency Virus (HIV)) that has not yet been started or completed, or the results of which are not yet known?<br>If "Yes", to either question 5a or 5b, complete the chart below. |                    |  |                                       |                 | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |
| Question #  | Name of child      | Diagnosis, date(s), treatment, present condition | Physician's name, address and phone # |                 |  |
|   |                    |  |                                       |                 |  |
|   |                    |  |                                       |                 |  |
|   |                    |  |                                       |                 |  |

## Financial Questions

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 6. Is there an intention, or an arrangement, that all or part of the insurance applied for will be:<br>a) Paid for by borrowing, financing or receiving money or any other property?<br>b) Transferred, assigned, sold or pledged?<br>If "Yes", to either question 6a or 6b provide details. _____<br>_____ |  |  |  |  | <input type="radio"/> Yes <input type="radio"/> No<br><input type="radio"/> Yes <input type="radio"/> No |
| 7. Has the proposed insured, owner or a beneficiary arranged, been offered, or received, an inducement, fee or compensation to buy, or pay for, the insurance applied for? If "Yes", provide details. _____<br>_____  |  |  |  |  | <input type="radio"/> Yes <input type="radio"/> No   |

For each "Yes" answer in the Lifestyle and Medical Questions sections additional information may be required. Completing the corresponding questionnaire or, if no corresponding questionnaire is available, providing details in the Additional Information section may help speed up the Underwriting process.

| <b>Lifestyle Questions (For these questions "You" and "Your" mean the proposed insured.)</b>   |  |
|--|--|
| 8. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify:<br>Type used: _____ Date last used: _____<br>If currently smoking, how many pack(s) per day? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 9. Do you currently drink alcohol? If "Yes", specify:<br>How many times per week? _____ How many drinks per occasion? _____  | <input type="radio"/> Yes <input type="radio"/> No   |
| 10. Within the past 10 years have you:<br>a) Used marijuana, heroin, cocaine, a narcotic, a barbiturate, a hallucinogen or a controlled substance except as prescribed by a licensed physician or medical practitioner?<br>b) Received or been advised to receive treatment or counseling, by a licensed physician or medical practitioner, to discontinue or reduce the use of alcohol, non-prescribed or prescribed drugs? | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |
| 11. Do you expect to travel outside of North America or change your country of residence within the next 2 years?  | <input type="radio"/> Yes <input type="radio"/> No   |
| 12. Have you received notice of deployment or are you currently deployed, on active duty or alert with the Military or the Reserves?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 13. Have you, within the past 2 years, flown, or do you in the future intend to fly, in an aircraft as a student pilot, licensed pilot or crew member?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 14. Have you, within the past 2 years, engaged, or do you in the future intend to engage, in motor vehicle or boat racing, mountain or rock climbing, scuba diving, skydiving, ballooning, hang gliding or ultra light flying?   | <input type="radio"/> Yes <input type="radio"/> No   |
| 15. Have you ever had your driver's license suspended or revoked or within the past 5 years had more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____<br>_____   | <input type="radio"/> Yes <input type="radio"/> No   |
| 16. Within the past 10 years have you:<br>a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", provide date, details and State where each conviction occurred. _____<br>_____<br>b) Been convicted of, pled guilty to, or are you currently on probation or incarcerated for, a felony? If "Yes", provide date(s) and reason(s). _____<br>_____                                | <input type="radio"/> Yes <input type="radio"/> No<br><br><input type="radio"/> Yes <input type="radio"/> No |

| <b>Medical Questions (For these questions "You" and "Your" mean the proposed insured. For each "Yes" answer, provide details in the Additional Information section.)</b>   |  |
|--|--|
| 17.<br>a) Your: Height: _____ Weight: _____<br>b) Have you had a weight change of 10 pounds or more, within the past 12 months? If "Yes", specify: <input type="radio"/> Gain <input type="radio"/> Loss<br>How many pounds? _____ Reason: _____ | <input type="radio"/> Yes <input type="radio"/> No |
| 18. Date you last consulted a physician: _____<br>Physician Name: _____ Address: _____<br>a) Reason(s): _____<br>b) Were results of that consultation within normal ranges? If "No," provide details. _____                                      | <input type="radio"/> Yes <input type="radio"/> No |

|   |                |               |  |
|---|----------------|---------------|--|
| 19. Your Personal Physician(s), if different than question 18.<br>Name: _____ Address: _____ Phone #: _____<br>Name: _____ Address: _____ Phone #: _____  |                |               |  |
| 20. Within the past 5 years, have you consulted a physician other than identified in question 18 or 19, or a medical practitioner, or been a clinic, hospital or emergency room patient?  |                |               | O Yes O No   |
| 21. Are you presently taking prescription medication or under treatment?  |                |               | O Yes O No   |
| 22. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?  |                |               | O Yes O No   |
| 23. Do you have, alive or deceased, a parent or sibling with a history, prior to age 65, of diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, or other hereditary disorder?<br>Details to "Yes" answers to question 23.   |                |               | O Yes O No   |
|   | Age, if living | Age, at death | Details of condition / Cause of death  |
| Father  |                |               |  |
| Mother  |                |               |  |
| Siblings  |                |               |  |
|   |                |               |  |
| 24. Within the past 5 years, have you:<br>a) Had or been advised to have a diagnostic test (other than for HIV) such as an EKG, CAT scan, MRI scan, echocardiogram, angiogram, biopsy, or endoscopy?<br>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?<br>c) Been unable to work at your regular job for more than 20 consecutive days or are you currently disabled?   |                |               | O Yes O No<br>O Yes O No<br>O Yes O 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:<br>a) High blood pressure, coronary artery disease, heart murmur, chest pain, irregular heart beat, aneurysm, stroke, Transient Ischemic Attack, circulatory surgery, a disease or disorder of the arteries or circulatory system or had a heart attack or heart surgery?<br>b) Anemia, high cholesterol, swollen glands or a disease or disorder of the blood or lymphatic system?<br>c) Cancer, tumor, polyp, cyst, melanoma, unexplained swelling or lump or a malignancy?<br>d) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, chronic cough, sleep apnea, or a disease or disorder of the respiratory system?<br>e) Seizures, epilepsy, dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, or a disease or disorder of the brain or nervous system?<br>f) Anxiety, depression, bi-polar disorder, schizophrenia, eating disorder, Post Traumatic Stress Disorder (PTSD) or a mental health disorder?<br>g) Blood or albumin in the urine or a disease or disorder of the prostate, bladder, kidney or genito-urinary organ?<br>h) Diabetes, or a disease or disorder of the thyroid, pituitary, pancreas or endocrine system?<br>i) Hepatitis, colitis, ileitis, gastritis, ulcer, Crohn's disease or a disease or disorder of the digestive system?<br>j) Arthritis, fibromyalgia, or a disease or disorder of the back, neck or musculoskeletal system?<br>k) Lupus or a disease or disorder of the immune system (other than HIV) or connective tissue? |                |               | O Yes O No<br>O Yes O No |

**Additional Information (Explain all "Yes" answers from the Medical Questions section.)**

| Question # | State diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone numbers (if different than question 19). |
|------------|---|
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|            |   |

## Payment Information and Authorization

The planned premium quoted may change following underwriting review.

|  |  |  |
|--|--|--|
| Payer is:                              |  |  |
| <input type="radio"/> Proposed insured | <input type="radio"/> Owner (if other than proposed insured) | <input type="radio"/> Other (complete Contingent Owner/Other Payer Form) |

|  |  |
|--|--|
| First premium payment to be made by:                       |  |
| <input type="radio"/> Draft via Pre-Authorized Check (PAC) | <input type="radio"/> Check (payable to Foresters) |

|                                      |                                   |
|--------------------------------------|-----------------------------------|
| Subsequent premium payments made by: |                                   |
| <input type="radio"/> PAC            | <input type="radio"/> Direct Bill |

|  |                                 |                                     |                                |
|--|---------------------------------|-------------------------------------|--------------------------------|
| Payment mode:                            |                                 |                                     |                                |
| <input type="radio"/> Monthly (PAC only) | <input type="radio"/> Quarterly | <input type="radio"/> Semi-annually | <input type="radio"/> Annually |

|   |   |   |
|---|---|---|
| PAC banking information (including drafting first premium) to be taken from:  |   |   |
| <input type="radio"/> Attached void check                                     | <input type="radio"/> Check submitted with this Application | <input type="radio"/> Information completed below (if no check available) |
| Type of account: <input type="radio"/> Checking <input type="radio"/> Savings |   |   |
| Name of financial institution: _____  |   |   |
| Street address: _____   |   |   |
| City: _____ State: _____ Zip: _____   |   |   |
| Transit #: _____ Account # : _____  |   |   |

### 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 and agrees that: 1) Foresters is authorized to draft deductions under the PAC plan from that account or another account later identified or substituted by the payer. 2) The financial institution from which payments 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, if any, will be made and the amount of that deduction for the product issued. 4) This PAC plan 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 agreement must be signed by the bank account owner as his/her name appears on bank records for the account provided.

X \_\_\_\_\_  
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.

### Temporary Life Insurance Agreement (TIA) Questions

|   |  |
|---|--|
| 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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

### Temporary Life Insurance Agreement (TIA) Acknowledgement

Will the TIA be left with the owner?

No. The owner acknowledges that there is no temporary insurance coverage in effect, even if first premium payment is provided or authorized.      X \_\_\_\_\_  
(Owner's initials)

Yes. Complete the TIA and leave it with the owner.  
 First premium payment, in the amount of \$ \_\_\_\_\_, is provided or authorized by (select same method chosen in the Payment Information and Authorization section):

Draft via Pre-Authorized Check (PAC) plan  
 Check

Although the first 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 applied for in this Application and is payable no later than the date this Application is signed.

### Declarations and Agreements

"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 in this Application, declare that: 1) I have read 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.

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 with Foresters. 3) No person, including a producer, has the authority to waive the disclosure of full, complete and truthful information or write down an answer to a question in this Application other than the answer provided to that person. 4) The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. 5) Failure to disclose all material facts may result in a loss of coverage and cancellation of the insurance contract. A material misrepresentation or untrue declaration may render the insurance contract issued, if any, voidable. All facts should be shown in this Application. 6) The insurance contract issued, if at all, as a result of this Application, is conditional on there being no change in the insurability of the proposed insured, or a child identified in this Application, if any, between the date this Application was signed by the proposed insured and the date that the insurance contract comes into effect, being either the issue date or delivery date of the insurance contract according to its terms. 7) 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.

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, including but not limited to, email and facsimile 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) If I have chosen to provide a current internet 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 and with intent to defraud Foresters, any other insurer, or other person(s), files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**Temporary Life Insurance Agreement (TIA) (Complete and leave with the owner only if all pre-conditions are met.)**

**Definitions** - "Application" means the Application for Individual Life Insurance of which this Agreement forms a part. "Producer" means the person who signed the Application as the producer. "Proposed Insured" and "Owner" mean the person(s) identified as such in the Application.

**Pre-Conditions to Temporary Coverage** - Subject to the terms of this Agreement, Foresters agrees to provide the temporary coverage set out in this Agreement, effective on the date the Application is signed by the owner, if each of the following pre-conditions are met: 1) The proposed insured is not age 71 or older on that date. 2) No more than \$1,000,000 insurance coverage on the life of the proposed insured is applied for in the Application, calculated by including the amount of the benefit applied for under each rider (except common carrier accidental death coverage if any) that is payable in the event of death of the proposed insured. 3) Each of the Temporary Life Insurance Agreement questions are answered 'No' and the 'No' answers shown are truthful and 4) No later than the date the Application is signed by the owner, first payment, at least equal to a monthly premium quoted for the insurance applied for in the Application, is provided or authorized. If one or more of the above pre-conditions are not met, no temporary coverage takes effect even if this Agreement was left with the owner.

**Temporary Life Insurance Agreement Questions**

|   |  |
|---|--|
| 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)?                      | <input type="radio"/> Yes <input type="radio"/> 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)?   | <input type="radio"/> Yes <input type="radio"/> 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? | <input type="radio"/> Yes <input type="radio"/> No |

**Amount of Temporary Coverage** - Subject to the terms of this Agreement, if all of the above pre-conditions are met and the proposed insured dies while this Agreement is in effect, Foresters shall pay, to the beneficiary(ies), as shown in the Application, under this and all other Foresters temporary life insurance agreement(s) insuring the life of the proposed insured, the lesser of a) \$500,000; or, b) the amount of insurance applied for in the Application on the life of the deceased proposed insured, including the amount payable for the death of the proposed insured under a rider applied for (except common carrier accidental death coverage if any).

**Termination of Temporary Coverage** - Subject to the terms of this Agreement, if temporary coverage takes effect under this Agreement, temporary coverage will terminate, and shall be of no further force or effect, on the earliest of the following: 1) Ninety (90) days from the date shown in the Application as the date that the Application was signed by the owner. That date shall be the first day for purposes of calculating this ninety (90) day period. 2) The date an approved Foresters certificate on the life of the proposed insured takes effect as described in that certificate, if a certificate is issued in response to the Application. 3) The date Foresters offers, as shown in Foresters records, the owner a Foresters certificate in response to, but not as applied for in, the Application. 4) The date a written or oral request to withdraw the Application or terminate this Agreement is made by or on behalf of the proposed insured or the owner. 5) The date written notice is sent by Foresters, as shown in Foresters records, to the proposed insured or the owner, terminating this Agreement or declining the Application.

**Special Limitations** - This Agreement shall be void if the first payment, regardless of method, is not honored when presented for payment. Fraud, material misrepresentation or non-disclosure in the Application will void this Agreement and limit Foresters liability to a refund of payment(s) made to Foresters. If the proposed insured dies by suicide, whether sane or insane, Foresters liability under this Agreement is limited to a refund of the payment(s) made to Foresters.

**Entire Agreement and Governing Law** - This Agreement contains the entire terms regarding temporary coverage. No one, including the producer, is authorized to waive, modify or change in writing, orally, or otherwise the terms of this Agreement or to promise or represent the terms of this Agreement other than as expressly written in this Agreement. This Agreement shall be governed by and subject to the laws of the State in which this Agreement was delivered to the owner.

**Acknowledgement** - I, the proposed insured and owner, if other than the proposed insured, by signing in the Signature Section of the Application, acknowledge and agree that I have reviewed, understand and accept the terms of this Temporary Life Insurance Agreement.

Countersigned,



George Mohacsi, President & Chief Executive Officer

## Authorization To Obtain And Disclose Information

This authorization is for the purpose of (a) assessing insurance coverage eligibility and premium amounts, (b) adjudicating claims and c) supporting the operations of our business. In this authorization, "proposed insured" means the proposed insured identified in this Application. "Child" means every child named, if any, and proposed for insurance, in this Application. 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, authorizes Foresters, its reinsurers and those who perform services for Foresters related to an application for insurance or a claim for benefits, to obtain an investigative consumer report and/or information about him/her from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; other insurer or institution; consumer reporting agency; pharmacy, pharmacy benefits manager or other pharmacy related services organization; or Medical Information Bureau, Inc ('MIB, Inc.'). 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. Foresters may make a brief report to MIB, Inc. about the proposed insured and each child. Foresters or its authorized representatives may disclose information to: its reinsurers; appointed producers, agencies and those who perform services for Foresters related to an application for insurance or a claim for benefits; or those companies to which the proposed insured has applied or may apply to for life or health insurance, or benefits. Disclosure may be made when required or permitted by law and the disclosed information may no longer be protected by federal privacy laws. This authorization shall be the consent required, whether implied or express, written or oral, by applicable law(s), including Federal and state legislation and regulations regarding the collection, retention, usage and disclosure of information about or related to the proposed insured, owner and each child. This authorization is valid for two years from the date of this Application. Foresters or its authorized representatives may use an original document or a copy of this authorization to obtain information. This authorization may be revoked at any time by written notice to Foresters, except that action(s) taken before written revocation will not be affected. A Notices page has been provided to the proposed insured. It includes the MIB, Inc. and Fair Credit Reporting Notices. A copy of this authorization will be provided upon request.

## Signature Section (For purposes of entire Application.)

X \_\_\_\_\_  
Signature of proposed insured (if the proposed insured is not a juvenile)

X \_\_\_\_\_  
Signature of owner (if other than proposed insured)

X \_\_\_\_\_  
Signature of parent/legal guardian (if the proposed insured is a juvenile  
and the owner is not a parent/guardian)

Each person signed at: \_\_\_\_\_  
(City, State)

Each person signed on: \_\_\_\_\_  
Date (mmm/dd/yyyy)

## 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 that might affect insurability; b) I personally met with the proposed insured and each child and asked the proposed insured and/or the owner each question as written in this Application to which an answer is shown, recorded those answers given to me by the proposed insured and owner, reviewed with each this Application before it was signed by that person, reviewed the document(s) used to verify identity and birth date and witnessed each signature in this Application; c) This Application has not been altered in any way after the proposed insured and owner signed it; d) 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; e) If applicable, I have disclosed that this Application may be transmitted to Foresters by electronic means and that this original Application may be destroyed after confirmation of successful transmission; f) 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.

Will the certificate applied for be a replacement for or change existing insurance or an annuity?

Yes  No

Are you related to the proposed insured?

Yes  No

\_\_\_\_\_  
Producer's full name

\_\_\_\_\_  
Producer #

X \_\_\_\_\_  
Signature of producer

\_\_\_\_\_  
Date (mmm/dd/yyyy)

## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for universal life insurance with lifetime no-lapse guarantee provision.)

|                         |                    |                  |
|-------------------------|--------------------|------------------|
| <b>Proposed Insured</b> |                    |                  |
| First name: _____       | Middle name: _____ | Last name: _____ |

### BIG Universal Life (with lifetime no-lapse guarantee provision.)

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____ | Planned premium: <input type="radio"/> Monthly <input type="radio"/> Quarterly<br>\$ _____ <input type="radio"/> Semi-annually <input type="radio"/> Annually |
| Initial lump sum premium:<br>\$ _____                                     | Source of lump sum premium:<br>_____  |

|  |  |  |
|--|--|--|
| <b>Riders (Subject to state and product availability.)</b> |  |  |
| <input type="radio"/> Accidental death:<br>\$ _____        | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Waiver of premium                    |  | <input type="radio"/> Other rider(s): _____                          |

|   |
|---|
| <b>Remarks:</b>   |
|   |
|   |
|   |
| 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. |

### Illustration Certification (The Owner and Producer MUST each indicate they have read and agree with their respective statement, below, if a signed illustration for the coverage(s) applied for is NOT enclosed with this Application.)

|   |
|---|
| <p><b>O Owner's Statement:</b> By signing the Application, I, the owner, acknowledge that I have NOT received an illustration for the product as applied for and understand that an illustration for the product as issued will be provided no later than the certificate delivery date.</p> <p><b>O Licensed Producer's Statement:</b> By signing the Application, I, the licensed producer, certify that I have NOT provided an illustration for the product as applied for. However, one will be provided no later than at the time of certificate delivery.</p> |
|---|

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



## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for SMART Universal Life insurance.)

|   |
|---|
| Proposed Insured                                      |
| First name: _____ Middle name: _____ Last name: _____ |

### SMART Universal Life

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____   | Planned premium: <input type="radio"/> Monthly <input type="radio"/> Quarterly<br>\$ _____ <input type="radio"/> Semi-annually <input type="radio"/> Annually |
| Life insurance qualification test:<br><input type="radio"/> Guideline Premium Test (GPT)<br><input type="radio"/> Cash Value Accumulation Test (CVAT) | Death benefit option:<br><input type="radio"/> Level<br><input type="radio"/> Increasing  |
| Initial lump sum premium:<br>\$ _____   | Source of lump sum premium:<br>_____  |

|  |  |  |
|--|--|--|
| <b>Riders (Subject to state and product availability.)</b> |  |  |
| <input type="radio"/> Accidental death:<br>\$ _____        | <input type="radio"/> Children's term:<br>\$ _____ | <input type="radio"/> Disability income (accident only):<br>\$ _____ |
| <input type="radio"/> Waiver of monthly deductions         |  | <input type="radio"/> Guaranteed purchase option                     |
| <input type="radio"/> Other rider(s): _____                |  |  |

|  |          |
|--|----------|
| <b>Complete if the proposed insured is a juvenile.</b>   |          |
| a) State amount of life insurance on primary caregiver.  | \$ _____ |
| b) Are all brothers and sisters insured for the same amount? If "No," state amount and reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No |          |
| c) Does the child live with the owner? If "No," provide reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No                                |          |

|   |
|---|
| Remarks:  |
|   |
| 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. |

|   |
|---|
| <b>Illustration Certification</b> (The Owner and Producer MUST each indicate they have read and agree with their respective statement, below, if a signed illustration for the coverage(s) applied for is NOT enclosed with this Application.)                                      |
| <b>Owner's Statement:</b> By signing the Application, I, the owner, acknowledge that I have NOT received an illustration for the product as applied for and understand that an illustration for the product as issued will be provided no later than the certificate delivery date. |
| <b>Licensed Producer's Statement:</b> By signing the Application, I, the licensed producer, certify that I have NOT provided an illustration for the product as applied for. However, one will be provided no later than at the time of certificate delivery.                       |

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

## The Independent Order of Foresters ("Foresters")

### Product Details (Complete and submit only if applying for universal life insurance with lifetime no-lapse guarantee provision.)

|   |
|---|
| <b>Proposed Insured</b>                               |
| First name: _____ Middle name: _____ Last name: _____ |

### Armor Universal Life (with lifetime no-lapse guarantee provision)

|   |   |
|---|---|
| Amount of life insurance applied for on the proposed insured:<br>\$ _____ | Planned premium: <input type="radio"/> Monthly <input type="radio"/> Quarterly<br>\$ _____ <input type="radio"/> Semi-annually <input type="radio"/> Annually |
| Initial lump sum premium:<br>\$ _____                                     | Source of lump sum premium:<br>_____  |

|   |   |  |
|---|---|--|
| <b>Riders (Subject to state and product availability.)</b>  |   |  |
| <input type="radio"/> Accidental death  | Percentage of face amount: <input type="radio"/> 25% <input type="radio"/> 50% <input type="radio"/> 75% <input type="radio"/> 100% |  |
| <input type="radio"/> Cost of living adjustment   | <input type="radio"/> Guaranteed purchase option  | <input type="radio"/> Waiver of premium        |
| <input type="radio"/> Children's term:<br>\$ _____  | <input type="radio"/> Disability income (accident only):<br>\$ _____  | <input type="radio"/> Other rider(s):<br>_____ |
| <input type="radio"/> Charity Percentage of face amount: <input type="radio"/> 5% <input type="radio"/> 10% <input type="radio"/> 15% |   |  |
| Indicate beneficiary below (must be a registered charity):  |   |  |
| <input type="radio"/> Children's Miracle Network (CMN)  |   |  |
| <input type="radio"/> Other: _____ (Name) _____ (Registered charity #, if available)  |   |  |
| _____ (Address)   |   |  |

|  |          |
|--|----------|
| <b>Complete if the proposed insured is a juvenile.</b>   |          |
| a) State amount of life insurance on primary caregiver.  | \$ _____ |
| b) Are all brothers and sisters insured for the same amount? If "No," state amount and reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No |          |
| c) Does the child live with the owner? If "No," provide reason in the Remarks section below. <input type="radio"/> Yes <input type="radio"/> No                                |          |

|   |
|---|
| <b>Remarks:</b>   |
|   |
| 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. |

### Illustration Certification (The Owner and Producer MUST each indicate they have read and agree with their respective statement, below, if a signed illustration for the coverage(s) applied for is NOT enclosed with this Application.)

|   |
|---|
| <input type="radio"/> <b>Owner's Statement:</b> By signing the Application, I, the owner, acknowledge that I have NOT received an illustration for the product as applied for and understand that an illustration for the product as issued will be provided no later than the certificate delivery date. |
| <input type="radio"/> <b>Licensed Producer's Statement:</b> By signing the Application, I, the licensed producer, certify that I have NOT provided an illustration for the product as applied for. However, one will be provided no later than at the time of certificate delivery.                       |

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