

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 2012 Reinstatement Application (Life)
Project Name/Number: /

Filing Company: The Independent Order of Foresters

Filing at a Glance

Company: The Independent Order of Foresters
Product Name: 2012 Reinstatement Application (Life)
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 09/11/2012
SERFF Tr Num: FRSS-128655552
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Jennifer Daigle, Kerry Shields, Tamara Levin, Gita Lakhan, Art Vikari, Gale Mcinally
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
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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: The Insurance Laws of Canada where this Society is domiciled does not require approval of this form.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 09/13/2012
 State Status Changed: 09/13/2012
 Deemer Date: Created By: Kerry Shields
 Submitted By: Tamara Levin Corresponding Filing Tracking Number:
 Filing Description:
 September 10, 2012
 RE: Independent Order of Foresters ("Foresters")
 NAIC #763-58068; FEIN: 980000680

Dear Sir or Madam:

Forms submitted for approval:

Form Number	Form Description
105709 US 10/12	Application for Reinstatement
105722 US 10/12	Spousal/Additional Insured Coverage - Underwriting Form

The forms listed above 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.

We have developed an application to be used for reinstatement of lapsed insurance contracts under our Whole Life (excluding our current final expense products), Universal Life and Term life insurance product portfolios and any similar products approved in the future. A separate form has been created to obtain information regarding insurability of a second person insured under a spouse or additional insured rider, for use when the certificate being reinstated includes such coverage. This spousal/additional insured form will also be used to obtain insurability information in conjunction with a change application, in situations where the change involves spousal/additional insured rider coverage. A new change application, currently being finalized, will be submitted for approval in the near future.

While these two new forms will not be replacing previously approved forms they will be used in place of the reinstatement portion of an existing previously approved form – 'Application for Change/Conversion/Reinstatement', 103107 US 05/02 approved May 30, 2002,

The forms can be completed and signed by all applicable parties in hardcopy, traditional format or, if a producer is involved, via electronic application software. 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 required font size.

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- Hardcopy: The forms will be completed by hand and wet signatures would be applied by all signees.
- Electronic: Producers would complete some or all of the forms using a computer or other mobile device. Producers will be provided with the option of printing the application for wet signature or utilizing an electronic signature process. Our proposed electronic application software is a wizard-based, intelligent fillable forms program. It will ensure that the proper application forms are utilized and the information collected is entered correctly, accurately, and securely. When completed electronically the questions and statements on the form will be identical to what was approved. PDFs of the completed form will be presented for review on screen by applicable persons whose signatures are required. Any incorrectly entered data can be corrected at this time prior to signatures being applied.

We certify that security measures will be in place to protect customer privacy. Foresters recognizes that the technology and regulations relating to computers, e-signatures, information security, and delivery is ever-changing and therefore we intend to remain flexible with our approach to ensure we can evolve and upgrade our technology for this process as needed in the future. Foresters confirms that our electronic process will comply with all federal and state regulations relating to digital/electronic signatures and information security, as well as meeting the requirements of all state insurance regulations.

Enclosed please find:

- Application for Reinstatement, submitted for approval.
- Spousal/Additional Insured Coverage - Underwriting Form, submitted for approval.
- Notices (Proposed Insured – 105718 US 10/12 & Spouse/Additional Insured – 105731 US 10/12), Containing MIB and privacy information, submitted as supporting documentation.
- Readability Certification.
- Statement of Variability.

If I may provide any additional information relating to this submission, please feel free to contact me at 416-429-3000, ext. 4310 or email tlevin@foresters.com.

Sincerely yours,

Tamara Levin
Compliance Analyst

Company and Contact

Filing Contact Information

Kerry Shields, Compliance Analyst
789 Don Mills Road
Toronto, ON M3C 1T9

kshields@foresters.com
416-429-3000 [Phone] 4066 [Ext]
416-467-2525 [FAX]

Filing Company Information

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

State: Arkansas

Filing Company: The Independent Order of Foresters

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: 2012 Reinstatement Application (Life)

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Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
The Independent Order of Foresters	\$100.00	09/11/2012	62564647

SERFF Tracking #:

FRSS-128655552

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

The Independent Order of Foresters

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2012 Reinstatement Application (Life)

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/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/13/2012	09/13/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Reinstatement	Tamara Levin	09/11/2012	09/11/2012
Form	Spousal/Additional Insured Coverage UW Form	Tamara Levin	09/11/2012	09/11/2012

SERFF Tracking #:

FRSS-128655552

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

The Independent Order of Foresters

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2012 Reinstatement Application (Life)

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/

Disposition

Disposition Date: 09/13/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Notices		Yes
Supporting Document	Statement of Variability		Yes
Form (revised)	Application for Reinstatement		Yes
Form (revised)	Spousal/Additional Insured Coverage UW Form		Yes
Form	Application for Reinstatement		Yes
Form	Spousal/Additional Insured Coverage UW Form		Yes

SERFF Tracking #:

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Company Tracking #:

State:

Arkansas

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Amendment Letter

Submitted Date: 09/11/2012

Comments:

The original files attached did not have Foresters head office and US mailing addresses, telephone number, website and corporate logo square bracketed to denote the variable material referenced in the Statement of Variability.

My apologies for the error.

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
105709 US 10/12	Application/Enrollment Form	Application for Reinstatement	Initial				51.400	105709 US 1012_Application for Reinstatement.pdf
105722 US 10/12	Application/Enrollment Form	Spousal/Additional Insured Coverage UW Form	Initial				50.600	105722 US 1012_Spousal-Additional Insured Coverage UW Form.pdf

State: Arkansas
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Form Schedule

Lead Form Number:							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		105709 US 10/12	AEF	Application for Reinstatement	Initial:	51.400	105709 US 1012_Application for Reinstatement.pdf
2		105722 US 10/12	AEF	Spousal/Additional Insured Coverage UW Form	Initial:	50.600	105722 US 1012_Spousal-Additional Insured Coverage UW Form.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

The Independent Order of Foresters ("Foresters")

Application for Reinstatement

Certificate #: _____

Reinstatement Type

O Maintain Original Issue Date – A reinstatement payment, in an amount determined by us, is required with this Application. If reinstatement is approved by us, the insurance contract will be reinstated with the same coverage(s) and value(s) as of the date of lapse.

O Re-Date Insurance Contract (*Only available within a year of a lapse that occurred during the first certificate year.*) – A reinstatement payment, of one modal total premium, is required with this Application. If reinstatement is approved by us, the insurance contract will be reinstated with a new issue date which may affect the issue age and the amount of the total premium. Each date, referred to in the insurance contract, that is measured from the issue date, will be measured from the new issue date.

Note: Foresters acceptance and/or collection of the reinstatement payment is done without prejudice of our right to decline reinstatement and no temporary coverage is provided.

Proposed Insured Information

First name:		Middle name:	Last name:		
Street address (cannot be a P.O. Box):					
City:		State:	Zip:	Date of birth (mmm/dd/yyyy):	Social security #:
Home phone #:	Alternate phone # / Cell #:		Email address (optional):		
Occupation & duties:					
Occupation details:					
<input type="radio"/> Full time		<input type="radio"/> Part time	<input type="radio"/> Seasonal	Income (past 12 months): \$ _____	
Hours worked per week (past 6 months): _____			Number of weeks worked in the past 12 months: _____		

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

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust:						
Street address (cannot be a P.O. Box.):				City:	State:	Zip:
City:		State:	Zip:	Social Security # / Tax I.D. #:		
Phone #:	Alternate phone # / Cell #:		Email address (optional):			

Spouse/Additional Insured Information (Complete only if the certificate being reinstated has a Spousal/Additional Insured Rider. A Spousal/Additional Insured Coverage – Underwriting Form must also be completed and submitted with this application.)

First name:		Middle name:	Last name:	
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Financial Question

Is there an intention, or an arrangement, that a person or entity, other than the owner, will obtain a right, title or interest in the certificate if reinstatement is approved (including possible assignment)?	<input type="radio"/> Yes <input type="radio"/> No
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Payment Information

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"/> Spouse/Additional insured <input type="radio"/> Other (complete Contingent Owner/Other Payer Form)
--

Reinstatement payment provided by: <input type="radio"/> Check (payable to Foresters) <input type="radio"/> Other (complete Payment Form)

Subsequent premium payments to be made by: <input type="radio"/> Pre-Authorized Check (PAC) (complete Payment Information Form) <input type="radio"/> Direct Bill <input type="radio"/> Other (complete Payment Form)

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

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.

Other Insurance (For purposes of these questions "you" and "your" mean the proposed insured.)

1. Do you have another annuity or life insurance application pending with Foresters or another insurer?					<input type="radio"/> Yes <input type="radio"/> No
2. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force?					<input type="radio"/> Yes <input type="radio"/> No
If "Yes", to either question 1 or 2, complete the chart below. Also include information about Foresters life insurance or annuity certificate(s).					
Name of Insurer	Annuity/Life insurance \$	Accidental death \$	Critical illness \$	Disability income (per month) \$	Issue year or indicate if pending
3. Have you 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

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.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the proposed insured.)

4. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify: Type used: _____ Date last used (mmm/dd/yyyy): _____ If currently smoking, how many pack(s) per day? _____	<input type="radio"/> Yes <input type="radio"/> No
5. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____	<input type="radio"/> Yes <input type="radio"/> No
6. Within the past 10 years have you: 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? 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 <input type="radio"/> Yes <input type="radio"/> No
7. Do you expect to travel outside of North America or change your country of residence within the next 2 years? If "Yes", indicate each that applies and provide the details requested: <input type="radio"/> Travel outside of North America: Country(ies): _____ Duration of travel (in weeks): _____ <input type="radio"/> Change country of residence: Country : _____	<input type="radio"/> Yes <input type="radio"/> No

8. 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
9. 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
10. 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
11. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
12. Within the past 10 years have you: a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: Number of convictions: _____ State where each conviction occurred: _____ Date of most recent conviction: _____ (mmm/dd/yyyy) 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). _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

Medical Questions (For purposes of these questions "you" and "your" mean the proposed insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

13. a) Your: Height: _____ Weight: _____ 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 How many pounds? _____ Reason: _____ _____	<input type="radio"/> Yes <input type="radio"/> No
14. Date you last consulted a physician: _____ Physician Name: _____ Phone #: _____ Address: _____ a) Reason(s): _____ b) Were you advised that results of that consultation were within normal ranges? If "No," provide details. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
15. Your Personal Physician(s), if different than question 14: Name: _____ Phone #: _____ Address: _____ Name: _____ Phone #: _____ Address: _____	
16. Within the past 5 years, have you consulted a physician other than identified in question 14 or 15, or a medical practitioner, or been a clinic, hospital or emergency room patient?	<input type="radio"/> Yes <input type="radio"/> No
17. Are you presently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> No
18. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> No

Declarations and Agreements

"Application" means this Application for Reinstatement and includes additional forms, if any, that are part of this Application. "I/Me" means individually each person identified in this Application as either the proposed insured or the owner, and the parent/legal guardian signing this Application if the proposed insured is a juvenile. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters.

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true.

I understand and agree that: 1) The statements and answers in this Application are the basis for the reinstatement of the insurance contract (defined as a certificate and each rider attached to that certificate) and, if approved, reinstatement will be subject to a new two year contestability period based upon the information provided in this Application. 2) No information about me will be considered to have been given to Foresters by me unless it is stated in this Application. 3) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. 4) Reinstatement of the insurance contract is effective on the date approved by us provided that: (a) the required reinstatement payment is provided in full on or before that date and is honored by the financial institution from which it is to be collected; and (b) between the date this Application was signed and the date, as shown in our records, that reinstatement of the insurance contract is approved by us, there is no event, no diagnosed change in health, or no change in habits or circumstances of the proposed insured or spouse/additional insured, that would require a change to an answer to a question in this Application. 5) If reinstatement is approved by us, this Application shall form part of the entire contract with Foresters. If reinstatement is not approved by us, our liability is limited to a refund of the reinstatement payment collected by us, if any.

I further understand and agree that: 1) This Application and related documents may be sent by electronic means. 2) 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. 3) If I have chosen to provide an email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 4) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization To Obtain And Disclose Information

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

Signature Section (For purposes of entire Application.)

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

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

The owner or the proposed insured, if the proposed insured is the owner, signed on (mmm/dd/yyyy) _____.

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

Parent/Legal guardian's signature: X _____



The Independent Order of Foresters ("Foresters")

Spousal/Additional Insured Coverage - Underwriting Form

Underwriting Form for the most recent: Application For Change Application For Reinstatement

on certificate #: _____.

Spouse/Additional Insured Information

First name:		Middle name:	Last name:	
Date of birth (mmm/dd/yyyy):	State & Country of birth:		Social security #:	
Home phone #:	Alternate phone # / Cell #:	Best time to call:	Email address (optional):	

Other Insurance (For purposes of these questions "you" and "your" mean the spouse/additional insured.)

1. Do you have another annuity or life insurance application pending with Foresters or another insurer?					O Yes O No
2. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force? If "Yes", to either question 1 or 2, complete the chart below. Also include information about Foresters life insurance or annuity certificate(s).					O Yes O No
Name of Insurer	Annuity/Life insurance \$	Accidental death \$	Critical illness \$	Disability income (per month) \$	Issue year or indicate if pending
3. Have you ever had an application for life, health, disability or critical illness insurance declined, rated or modified? If "Yes", provide date _____ and reason _____					O Yes O 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.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the spouse/additional insured.)

4. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify: Type used: _____ Date last used (mmm/dd/yyyy): _____ If currently smoking, how many pack(s) per day? _____		O Yes O No
5. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____		O Yes O No
6. Within the past 10 years have you: 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? 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?		O Yes O No O Yes O No
7. Do you expect to travel outside of North America or change your country of residence within the next 2 years? If "Yes", indicate each that applies and provide the details requested: O Travel outside of North America: Country(ies): _____ Duration of travel (in weeks): _____ O Change country of residence: Country : _____		O Yes O No

8. 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
9. 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
10. 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
11. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
12. Within the past 10 years have you: a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: Number of convictions: _____ State where each conviction occurred: _____ Date of most recent conviction: _____ (mmm/dd/yyyy)	<input type="radio"/> Yes <input type="radio"/> No
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). _____ _____	<input type="radio"/> Yes <input type="radio"/> No

Medical Questions (For purposes of these questions "you" and "your" mean the spouse/additional insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

13. a) Your: Height: _____ Weight: _____ 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 How many pounds? _____ Reason: _____ _____	<input type="radio"/> Yes <input type="radio"/> No
14. Date you last consulted a physician: _____ Physician Name: _____ Phone #: _____ Address: _____ a) Reason(s): _____ b) Were you advised that results of that consultation were within normal ranges? If "No," provide details. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
15. Your Personal Physician(s), if different than question 14: Name: _____ Phone #: _____ Address: _____ Name: _____ Phone #: _____ Address: _____	
16. Within the past 5 years, have you consulted a physician other than identified in question 14 or 15, or a medical practitioner, or been a clinic, hospital or emergency room patient?	<input type="radio"/> Yes <input type="radio"/> No
17. Are you presently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> No
18. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> No

Declarations and Agreements

"Application" means the application identified in this form. "I/Me" means the person identified in this form as the spouse/additional insured. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters.

I, as evidenced by my signature in this form, declare that: 1) I have reviewed this form. 2) I was asked every question that applies to me and provided the answers shown, in this form, to these questions. 3) The statements, answers, and representations contained in this form are full, complete and true.

I understand and agree that: 1) This form is part of and subject to the Application. 2) The information provided in this form will be relied upon as evidence of insurability that will influence the assessment and acceptance of the Application by Foresters. 3) No information about me will be considered to have been given to Foresters by me unless it is stated in this form. 3) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract (defined as a certificate and each rider attached to that certificate). No person is authorized to advise me that any untrue or incomplete answer or information is acceptable.

I further understand and agree that: 1) The Application and related documents may be sent by electronic means. 2) 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 form or number(s) that I later provide. 3) If I have chosen to provide an email address in this form or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 4) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization To Obtain And Disclose Information

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

Signature Section (For purposes of entire form.)

Spouse/Additional insured's signature: _____

Signed on: _____
(mmm/dd/yyyy)

SERFF Tracking #:

FRSS-128655552

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

The Independent Order of Foresters

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2012 Reinstatement Application (Life)

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR_Readable Score Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Notices		
Comments:			
Attachment(s):			
105718 US 1012_Notices_Reinstatement.pdf			
105731 US 1012_Notices Spouse Rider UW Form.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
AR_Statement of Variability.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

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:

<u>Form Name</u>	<u>Form Number</u>	<u>Flesch Score</u>
Application for Reinstatement	105709 US 10/12	51.4
Spousal/Additional Insured Coverage Underwriting Form	105722 US 10/12	50.6

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.


Digitally signed by ca,
Tamara Levin
DN: c=ca, o=iodefentrust,
cn=ca, ou=ciscovpn,
cn=Tamara Levin
Date: 2012.09.11 11:16:53
-04'00'

September 11, 2012

Hendrik Verdurmen
Vice President, Finance & Product Management

Date

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

For purposes of this Notice the following words and phrases are defined: "Application" means the Application for Reinstatement to which this Notice relates; "Foresters", "we", "our", and "us" mean The Independent Order of Foresters; "Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an insurance related application, insurance product, benefit claim or supporting Foresters business operations; "You" and "Your" mean the proposed insured identified in the Application. If you have questions regarding your Application contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. 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, between and among Foresters and authorized persons, to consumer reporting agencies hired to prepare consumer reports or consumer investigative reports, to companies to which you have applied for insurance coverage or benefits, and to 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 MIB, Inc. ("MIB"). You can make a 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 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.

MIB, Inc. - Information regarding your insurability will be treated as confidential. Foresters or authorized persons 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 about you 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Notices (This page must be given to the spouse/additional insured.)

For purposes of this Notice the following words and phrases are defined: "Form" means the Spousal/Additional Insured Coverage – Underwriting Form to which this Notice relates; "Foresters", "we", "our", and "us" mean The Independent Order of Foresters; "Authorized persons" means reinsurers, insurance agents and agencies and those performing services in relation to an insurance related application, insurance product, benefit claim or supporting Foresters business operations; "You" and "Your" mean the spouse/additional insured identified in the Form. If you have questions regarding your Form contact us directly at 1-800-828-1540. If you have questions regarding privacy contact Foresters Chief Privacy Officer or regarding underwriting or MIB, Inc. contact Foresters Chief Underwriter. You can write to either at 789 Don Mills Road Toronto, Canada M3C 1T9, or to our U.S. Mailing Address at P.O. 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, between and among Foresters and authorized persons, to consumer reporting agencies hired to prepare consumer reports or consumer investigative reports, to companies to which you have applied for insurance coverage or benefits, and to 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 MIB, Inc. ("MIB"). You can make a 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 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 Form 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.

MIB, Inc. - Information regarding your insurability will be treated as confidential. Foresters or authorized persons 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 about you 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

The Independent Order of Foresters

Statement of Variability

Application for Reinstatement

105709 US 10/12

Spousal/Additional Insured Coverage – Underwriting Form

105722 US 10/12

Page 1

1. Foresters head office and US mailing addresses, telephone number, website and corporate logo are bracketed to allow for change if Foresters moves, rebrands or changes its phone number.

All Pages, footer

1. The 'form identifier', when present, is used by a Foresters form tracking system for administrative purposes only. Example – may be a bar code or serial number.

SERFF Tracking #:

FRSS-128655552

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

The Independent Order of Foresters

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2012 Reinstatement Application (Life)

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)
09/11/2012	Form	Application for Reinstatement	09/11/2012	105709 US 1012_Application for Reinstatement.pdf (Superseded)
09/11/2012	Form	Spousal/Additional Insured Coverage UW Form	09/11/2012	105722 US 1012_Spousal-Additional Insured Coverage UW Form.pdf (Superseded)

The Independent Order of Foresters ("Foresters")

Application for Reinstatement

Certificate #: _____

Reinstatement Type

O Maintain Original Issue Date – A reinstatement payment, in an amount determined by us, is required with this Application. If reinstatement is approved by us, the insurance contract will be reinstated with the same coverage(s) and value(s) as of the date of lapse.

O Re-Date Insurance Contract (*Only available within a year of a lapse that occurred during the first certificate year.*) – A reinstatement payment, of one modal total premium, is required with this Application. If reinstatement is approved by us, the insurance contract will be reinstated with a new issue date which may affect the issue age and the amount of the total premium. Each date, referred to in the insurance contract, that is measured from the issue date, will be measured from the new issue date.

Note: Foresters acceptance and/or collection of the reinstatement payment is done without prejudice of our right to decline reinstatement and no temporary coverage is provided.

Proposed Insured Information

First name:		Middle name:	Last name:		
Street address (cannot be a P.O. Box.):					
City:		State:	Zip:	Date of birth (mmm/dd/yyyy):	Social security #:
Home phone #:	Alternate phone # / Cell #:		Email address (optional):		
Occupation & duties:					
Occupation details:					
<input type="radio"/> Full time		<input type="radio"/> Part time	<input type="radio"/> Seasonal	Income (past 12 months): \$ _____	
Hours worked per week (past 6 months): _____			Number of weeks worked in the past 12 months: _____		

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

Full legal name of Individual (First, Middle, Last), Organization, Charity, Business or Trust:						
Street address (cannot be a P.O. Box.):				City:	State:	Zip:
City:		State:	Zip:	Social Security # / Tax I.D. #:		
Phone #:	Alternate phone # / Cell #:		Email address (optional):			

Spouse/Additional Insured Information (Complete only if the certificate being reinstated has a Spousal/Additional Insured Rider. A Spousal/Additional Insured Coverage – Underwriting Form must also be completed and submitted with this application.)

First name:		Middle name:	Last name:		
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Financial Question

Is there an intention, or an arrangement, that a person or entity, other than the owner, will obtain a right, title or interest in the certificate if reinstatement is approved (including possible assignment)?	<input type="radio"/> Yes <input type="radio"/> No
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Payment Information

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"/> Spouse/Additional insured <input type="radio"/> Other (complete Contingent Owner/Other Payer Form)
--

Reinstatement payment provided by: <input type="radio"/> Check (payable to Foresters) <input type="radio"/> Other (complete Payment Form)

Subsequent premium payments to be made by: <input type="radio"/> Pre-Authorized Check (PAC) (complete Payment Information Form) <input type="radio"/> Direct Bill <input type="radio"/> Other (complete Payment Form)

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

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.

Other Insurance (For purposes of these questions "you" and "your" mean the proposed insured.)

1. Do you have another annuity or life insurance application pending with Foresters or another insurer?					<input type="radio"/> Yes <input type="radio"/> No
2. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force? 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. Have you 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

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.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the proposed insured.)

4. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify: Type used: _____ Date last used (mmm/dd/yyyy): _____ If currently smoking, how many pack(s) per day? _____	<input type="radio"/> Yes <input type="radio"/> No
5. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____	<input type="radio"/> Yes <input type="radio"/> No
6. Within the past 10 years have you: 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? 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 <input type="radio"/> Yes <input type="radio"/> No
7. Do you expect to travel outside of North America or change your country of residence within the next 2 years? If "Yes", indicate each that applies and provide the details requested: <input type="radio"/> Travel outside of North America: Country(ies): _____ Duration of travel (in weeks): _____ <input type="radio"/> Change country of residence: Country : _____	<input type="radio"/> Yes <input type="radio"/> No

8. 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
9. 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
10. 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
11. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
12. Within the past 10 years have you: a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: Number of convictions: _____ State where each conviction occurred: _____ Date of most recent conviction: _____ (mmm/dd/yyyy) 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). _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

Medical Questions (For purposes of these questions "you" and "your" mean the proposed insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

13. a) Your: Height: _____ Weight: _____ 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 How many pounds? _____ Reason: _____ _____	<input type="radio"/> Yes <input type="radio"/> No
14. Date you last consulted a physician: _____ Physician Name: _____ Phone #: _____ Address: _____ a) Reason(s): _____ b) Were you advised that results of that consultation were within normal ranges? If "No," provide details. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
15. Your Personal Physician(s), if different than question 14: Name: _____ Phone #: _____ Address: _____ Name: _____ Phone #: _____ Address: _____	
16. Within the past 5 years, have you consulted a physician other than identified in question 14 or 15, or a medical practitioner, or been a clinic, hospital or emergency room patient?	<input type="radio"/> Yes <input type="radio"/> No
17. Are you presently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> No
18. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> No

Declarations and Agreements

"Application" means this Application for Reinstatement and includes additional forms, if any, that are part of this Application. "I/Me" means individually each person identified in this Application as either the proposed insured or the owner, and the parent/legal guardian signing this Application if the proposed insured is a juvenile. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters.

I, as evidenced by my signature(s) in this Application, declare that: 1) I have reviewed this Application. 2) I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. 3) The statements, answers, and representations contained in this Application are full, complete and true.

I understand and agree that: 1) The statements and answers in this Application are the basis for the reinstatement of the insurance contract (defined as a certificate and each rider attached to that certificate) and, if approved, reinstatement will be subject to a new two year contestability period based upon the information provided in this Application. 2) No information about me will be considered to have been given to Foresters by me unless it is stated in this Application. 3) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract. No person is authorized to advise me that any untrue or incomplete answer or information is acceptable. 4) Reinstatement of the insurance contract is effective on the date approved by us provided that: (a) the required reinstatement payment is provided in full on or before that date and is honored by the financial institution from which it is to be collected; and (b) between the date this Application was signed and the date, as shown in our records, that reinstatement of the insurance contract is approved by us, there is no event, no diagnosed change in health, or no change in habits or circumstances of the proposed insured or spouse/additional insured, that would require a change to an answer to a question in this Application. 5) If reinstatement is approved by us, this Application shall form part of the entire contract with Foresters. If reinstatement is not approved by us, our liability is limited to a refund of the reinstatement payment collected by us, if any.

I further understand and agree that: 1) This Application and related documents may be sent by electronic means. 2) 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. 3) If I have chosen to provide an email address in this Application or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 4) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization To Obtain And Disclose Information

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

Signature Section (For purposes of entire Application.)

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

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

The owner or the proposed insured, if the proposed insured is the owner, signed on (mmm/dd/yyyy) _____.

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

Parent/Legal guardian's signature: X _____

The Independent Order of Foresters ("Foresters")

Spousal/Additional Insured Coverage - Underwriting Form

Underwriting Form for the most recent: Application For Change Application For Reinstatement

on certificate #: _____.

Spouse/Additional Insured Information

First name:		Middle name:	Last name:	
Date of birth (mmm/dd/yyyy):	State & Country of birth:		Social security #:	
Home phone #:	Alternate phone # / Cell #:	Best time to call:	Email address (optional):	

Other Insurance (For purposes of these questions "you" and "your" mean the spouse/additional insured.)

1. Do you have another annuity or life insurance application pending with Foresters or another insurer?					<input type="radio"/> Yes <input type="radio"/> No
2. Do you currently have an annuity or life, accidental death, critical illness or disability income insurance pending or in force? 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. Have you 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

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.

Lifestyle Questions (For purposes of these questions "you" and "your" mean the spouse/additional insured.)

4. Have you ever used tobacco in any form, or another nicotine product? If "Yes", specify: Type used: _____ Date last used (mmm/dd/yyyy): _____ If currently smoking, how many pack(s) per day? _____		<input type="radio"/> Yes <input type="radio"/> No
5. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____		<input type="radio"/> Yes <input type="radio"/> No
6. Within the past 10 years have you: 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? 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 <input type="radio"/> Yes <input type="radio"/> No
7. Do you expect to travel outside of North America or change your country of residence within the next 2 years? If "Yes", indicate each that applies and provide the details requested: <input type="radio"/> Travel outside of North America: Country(ies): _____ Duration of travel (in weeks): _____ <input type="radio"/> Change country of residence: Country : _____		<input type="radio"/> Yes <input type="radio"/> No

8. 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
9. 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
10. 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
11. Have you ever had your driver's license suspended or revoked or within the past 5 years been convicted of or pled guilty to more than 3 moving violations? If "Yes", provide date, details and State where each occurred. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
12. Within the past 10 years have you: a) Been convicted of driving while impaired or under the influence of alcohol or a drug? If "Yes", specify: Number of convictions: _____ State where each conviction occurred: _____ Date of most recent conviction: _____ (mmm/dd/yyyy) 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). _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No

Medical Questions (For purposes of these questions "you" and "your" mean the spouse/additional insured, "diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. For each "Yes" answer, provide details in the Additional Information section.)

13. a) Your: Height: _____ Weight: _____ 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 How many pounds? _____ Reason: _____ _____	<input type="radio"/> Yes <input type="radio"/> No
14. Date you last consulted a physician: _____ Physician Name: _____ Phone #: _____ Address: _____ a) Reason(s): _____ b) Were you advised that results of that consultation were within normal ranges? If "No," provide details. _____ _____	<input type="radio"/> Yes <input type="radio"/> No
15. Your Personal Physician(s), if different than question 14: Name: _____ Phone #: _____ Address: _____ Name: _____ Phone #: _____ Address: _____	
16. Within the past 5 years, have you consulted a physician other than identified in question 14 or 15, or a medical practitioner, or been a clinic, hospital or emergency room patient?	<input type="radio"/> Yes <input type="radio"/> No
17. Are you presently taking prescription medication or under treatment?	<input type="radio"/> Yes <input type="radio"/> No
18. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="radio"/> Yes <input type="radio"/> No

Declarations and Agreements

"Application" means the application identified in this form. "I/Me" means the person identified in this form as the spouse/additional insured. "Foresters", "we", "our", and "us" mean The Independent Order of Foresters.

I, as evidenced by my signature in this form, declare that: 1) I have reviewed this form. 2) I was asked every question that applies to me and provided the answers shown, in this form, to these questions. 3) The statements, answers, and representations contained in this form are full, complete and true.

I understand and agree that: 1) This form is part of and subject to the Application. 2) The information provided in this form will be relied upon as evidence of insurability that will influence the assessment and acceptance of the Application by Foresters. 3) No information about me will be considered to have been given to Foresters by me unless it is stated in this form. 3) A material misrepresentation, or untrue declaration, or failure to disclose all material facts, may result in loss of coverage or cancellation of the insurance contract (defined as a certificate and each rider attached to that certificate). No person is authorized to advise me that any untrue or incomplete answer or information is acceptable.

I further understand and agree that: 1) The Application and related documents may be sent by electronic means. 2) 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 form or number(s) that I later provide. 3) If I have chosen to provide an email address in this form or choose to provide one in the future, Foresters may use that address to send messages or documents to me electronically. 4) Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization To Obtain And Disclose Information

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

Signature Section (For purposes of entire form.)

Spouse/Additional insured's signature: _____

Signed on: _____
(mmm/dd/yyyy)