

A Guide to Completing the Application

Armor & Strong Foundation

NEW

- Application pages reduced to 13 (from 17)
- Minimum pages to be returned reduced to 9 (from 14)
- Only one copy of TIA will be required
- Single-sided application available for download and order
- First premium on PAC (FPOP)
- TIA now available on applications up to \$1M (increased from \$500K)

The Independent Order of Foresters ("Foresters") U.S. Mailing Address: www.foresters.com
789 Don Mills Road P.O. Box 179 T. 800 828 1540
Toronto, Canada M3C 1T9 Buffalo, NY 14201-0179

Foresters
Investing · Sharing · Inspiring

A Fraternal Benefit Society

Instructions Checklist for Application for Individual Life Insurance
This form is for internal and producer use only and is not part of the Application.

Do you have the correct Application?

- The Application must be the current version approved for use in the state where solicitation occurs. The application consists of:
 1. Product Details Page 77#### US 08/07
 2. Application for Individual Life Insurance 77#### US 05/07
 3. Any required supplemental coverage application forms, if supplemental coverage is being applied for.

Avoid Delays

- For any explanations, where space is insufficient, you may use a separate page, which must be signed and dated by the proposed life insured and the owner, if other than the proposed life insured.
- The Signature Section is complete with all applicable signature(s).
- The Producer Report is complete.
- The producer, the proposed life insured and the owner, if other than the proposed life insured, have initialed ALL corrections.
- The appropriate Product Details Page, showing details of the certificate and riders (if any) being applied for, is complete.
- As with most legal documents, do not use white-out (liquid paper) on any part of the Application.
- Notice of Information Procedures left with the proposed life insured.

Temporary Life Insurance Agreement (TIA)

- Do not complete the TIA Questions section or the TIA Agreement if you know that the pre-conditions, shown in the TIA Agreement (page 9), will not be met, however the TIA Acknowledgement section must be completed in all cases.
- The TIA Questions section of the Application and, if applicable, the TIA itself have been completed.
- If the Pre-Conditions to the TIA are met, including the first payment being made by an acceptable method, the TIA has been given to the owner.
- If the Pre-Conditions to the TIA are not met, the owner has initialed the acknowledgement accordingly and the TIA has not been left with the owner.

Supplemental Forms/ Disclosures

- Supplemental and disclosure/outline of coverage forms are complete with signature(s) (if required).
- If replacing existing insurance or an annuity, the applicable replacement form has been included (if required).
- A signed illustration has been included (if required).
- Notice of Consent for Blood and Body Fluid Testing has been included (if required).

Payment of Premiums

- Payments by check, bank draft or money order must be made out to "Foresters".
- If the initial payment is being made by check, bank draft or money order it must be dated no later than the date the Application was signed by the owner.
- If PAC has been requested, all PAC requirements have been met and PAC has been fully explained to the payer.
- If the initial premium payment is being made by PAC then the payer is aware that the PAC authorization is effective immediately.
- Cash is not permitted for the payment of premium.
- Producer cannot make premium payments (unless the proposed life insured is the producer or a dependent of the producer).
- If submitting the Application electronically, remember to include a photocopy of the void check, if one was provided for PAC purposes.

Faxing and Shipping Instructions

- Mail to: Foresters, Attn: New Business, PO Box 179 Buffalo NY 14201-0179
- Courier to: Foresters, Attn: New Business, c/o Frontier Distributing 1000 Young St. Suite 160 Tonawanda NY 14150
- Fax to: Foresters, Attn: New Business, fax number: 1-866-300-3830 (Checks must be mailed or couriered).

For applications submitted electronically Foresters, within 1 business day of receipt, will reply confirming the number of pages received. If confirmation is not received within 1 business day, call Foresters New Business at 1-866-466-7166 ext. 4025.

77#### US ##/07 77#### US ##/07

Product Details Page - Armor

Print legibly in ink. Any corrections must be initialed by the owner, proposed life insured and the producer. Please do not use any white out.

Enter Proposed Life Insured basic information

Charity rider: Additional coverage of 5%, 10% or 15% of initial face amount where the beneficiary is Children's Miracle Network or a legally registered charity.

Enter the planned modal premium

Reminder

- A signed illustration is required at time of application
- Fill in the amount of life insurance
- If riders are selected, the appropriate circle must be filled in along with an amount (if applicable). For Children's Term and Disability Income Riders, the supplemental forms must be filled

Issue Instructions:

- Provide details on how to issue certificates that are not approved as applied for. For example:
 - Maintain premium amount,
 - Maintain face amount of insurance,
 - Contract Producer before issue
- If the proposed life insured does not qualify for Simplified Issue the producer will be advised and will be asked if they wish to proceed with the Fully Underwritten product at the minimum Fully Underwritten amount

Product Details Page – Strong Foundation

Print legibly in ink. Any corrections must be initialed by the owner, proposed life insured and producer. Please do not use white out.

First name: _____ Middle name: _____ Last name: *Doe*

Proposed life insured state: *Michigan*

Amount of life insured applied for on the proposed life insured: \$ *100,000.00*

Instructions

Indicate below the type of coverage, including rider(s), if any, being applied for. Note: An asterisk (*) indicates that a supplemental coverage application form must be completed, signed and submitted with the Application if this type of rider coverage is being applied for.

Term Life

Strong Foundation Simplified issue Fully underwritten

If applying for simplified issue, provide details of the life event:

Mortgage amount: \$ *300,000* Name and address of lending institution: *ABC Bank*

Marriage Divorce Birth or adoption of a child Death of spouse

Date of life event: *Oct. 1, 2007*

Term 10 year 15 year 20 year 30 year Other:

Available riders (if applicable to selected plan):

Accidental death Percentage of face amount: 25% 50% 75% 100%

Waiver of premium

Living rewards (not available on 10 year term plans)

Children's term* \$ 10,000.00

Critical illness (accelerated death benefit)* \$ *50,000.00*

Disability income (accident only)* \$ *2,000.00*

Other rider(s): _____

Universal Life

Passport

Death benefit option: Level insured amount Level insured amount plus account value.

Available riders (if applicable to selected plan):

Accidental death \$ _____ Disability waiver

Children's term* \$ 10,000.00 Guaranteed purchase option

Member term \$ _____ Secondary guarantee

Other rider(s): _____

Planned modal premium: \$ _____ Initial lump sum premium: \$ _____

If underwriting approval is given other than as applied for, issue the certificate as follows:

Maintain premium amount Maintain face amount Contact producer before issue.

Special instructions:

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Proposed Life Insured and Residence State:

- Ensure the name and state entered here match the proposed life insured name and state entered on page 1 of the Application for Individual Life insurance.

Product Details:

- Fill in the amount and select one term
- 10 year term not available on non-medical basis

Rider Details:

- Select the desired rider(s) – the appropriate circle must be filled in along with an amount (where applicable).
- For Disability Income, Children's Term and Critical Illness Riders, the supplemental forms must be filled

Issue Instructions:

- Provide details on how to issue certificates that are approved not as applied for.
- If the proposed life insured does not qualify for Simplified Issue, the producer will be notified and asked if they wish to proceed with the Fully Underwritten product at the minimum FU amount.

Sections 1 & 2: General Information

Print legibly in ink. Any corrections must be initialed by the owner, proposed life insured and the producer.

Record General Information:

Proposed Life Insured:

Record the responses to every question. If a question is blank or incomplete you may have to contact the proposed life insured for additional information

Producer Must be Present:

Complete the application in the presence of the proposed life insured to verify his/her good health and to witness the signature(s) on the application

Owner

The owner can be the proposed life insured or a 3rd party (e.g business, trust or individual with an insurable interest)

Fill out the owner information only if the proposed life insured is not the owner or when applying for juvenile insurance

Owner Information

A Fraternal Benefit Society
Application for Individual Life Insurance

1.0 Proposed Life Insured (PLI)

First name: John Middle name: Chris Last name: Doe
 Legal Residence (No P.O. Box):
 Line 1: 123 Mackenzie Drive
 Line 2:
 City: Dearborn State: MI Zip code: 48185 Years at current address: 12
 Best time to call: 800/xxx Home phone number: (712) 734 - 3434 Cell phone number: (712) 456 - 0831
 Male Female Marital status: Married Divorced Widowed Social security number: 123 45 6789
 Separated Single
 Date of birth: Jun/06/1975 Photo I.D. used to verify identity and birth date:
 Birth state: MI Birth country: USA Driver's license number and state: M1234 8765 MI
 Passport
 A citizen of the United States? Yes No
 If 'No', what is the country of citizenship? Other government I.D.:
 What is the visa type? What was the date of arrival in the U.S.?
 Employed? Yes If 'Yes', employment is: Full time Part time Seasonal
 No If 'No', state reason:
 Work phone number: (712) 212-1111 Ext. _____ Years with current employer: 12 Annual income \$ 40,000
 Occupation (include duties): Office assistant Net worth \$ 200,000
 A Foresters member? No, applying for membership. Yes, certificate number(s) are:

2.0 Owner (Complete only if other than proposed life insured. If a contingent owner is to be named, use supplemental form.)

Address for owner: Line 1: _____
 Line 2: _____ City: _____ State: _____
 Owner is an individual.
 First name: _____ Middle name: _____ Last name: _____
 Male Female Date of birth: _____ Birth state: _____ Birth country: _____
 Home phone number: () - - Social security number: _____
 Relation to proposed life insured:
 Photo I.D. used to verify identity and birth date:
 Driver's license number and state:
 Passport Other government I.D.: _____
 A citizen of the United States? Yes No If 'No', what is the country of citizenship?
 If the owner is other than an individual, it is a: Corporation Partnership Trust Other:
 Entity/Trust name:
 If owner is a trust: Date of trust agreement: _____
 Name and address of trustee: _____

770197 AZ 01/08 Page 1 of 10

Section 3: Beneficiary Information

Fill out the proposed life insured's beneficiary and contingent beneficiary's address only if different from that of the proposed life insured's.

3.0 Beneficiary Information. (Each beneficiary designation below is irrevocable. If the beneficiary designation is to be irrevocable, insert the word "irrevocable" in the name of that beneficiary.)

Name of each primary beneficiary. (Include address if different from that of proposed life insured.)	Relationship to PLI	% Share
Susan Doe	Spouse	100
		total must equal 100%
Name of each contingent beneficiary. (Include address if different from that of proposed life insured.)	Relationship to PLI	% Share
Jack Doe 12 Mill St, Dearborn MI 48179	Father	100
		total must equal 100%

4.0 Other Insurance

Does the proposed life insured currently have life, accidental death, critical illness or disability income insurance in force? Yes No
If "Yes", please fill in the information below. Also include information about Foresters life insurance certificate(s).

Name of Insurer	Life Insurance \$	Accidental Death \$	Critical Illness \$	Disability Income \$	Issue Year

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

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

If "Yes", complete the required, State and Foresters, replacement/rollover/surrender/disclosure forms. Include existing life insurance or annuities in the process of being lapsed or surrendered, and those completed within the past 13 months.

If "Yes" to either of the two questions above, enter the details:

5.0 Medical Information.

Proposed life insured's:

5.1 a) Height is? 6 feet 2 inches b) Weight is? 270 pounds

c) Has there been an increase or decrease of more than 10 pounds in the past year? Yes No

If "Yes", state the reason and the amount of weight increase or decrease:

5.2 Primary care physician or medical practitioner is?

Name: Dr. Brown Phone number: (712) 123-4560

Address: 7 Pine Blvd., Dearborn MI 48112

5.3 a) Date of last consultation with a physician/medical practitioner was? Jan/31/2006

b) Reason for, and result of, consultation was? Fitness Test

c) Last consultation was with primary care physician/medical practitioner named in 5.2 above? Yes No

If "No", the last consultation was with the following physician/medical practitioner:

Name: _____ Phone number: (____) _____ - _____

Address: _____

Beneficiary:

- The proceeds of the certificate must benefit the proposed insured's surviving family or estate (directly or indirectly). Acceptable beneficiaries are any dependents, spouse, children, 3rd party business or designated charities
- If a 3rd party business is designated as a beneficiary you must detail in the Producer Report, how the death proceeds will benefit the family
- Creditors may have an insurable interest, but they should generally not be named as beneficiaries. A collateral assignment can be completed in favor of the creditor
- If the beneficiary is a minor, it is advantageous to name a trustee (should the proceeds become payable before the beneficiary's age of majority). State the relationship of the trustee to the proposed life insured

Sections 4 & 5: Other Insurance and Medical Information

Other Insurance:

- Indicate all policies in-force, including group and whether in-force insurance will be replaced
- Producers must comply with any replacement laws and regulations and are expected to offer suitable products and services to meet the proposed life insured's needs. Please refer to ezbiz (Tools & Resources -> Toolkit) for details.

Medical Information

- Provide the name and address for the proposed life insured's physician
 - Two addresses will be required if the most recent visit to the doctor was not the primary care physician

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

Name of each primary beneficiary. (Include address if different from that of proposed life insured.)	Relationship to PLI	% Share
Susan Doe	Spouse	100 total must equal 100%
Name of each contingent beneficiary. (Include address if different from that of proposed life insured.)		
Jack Doe 12 Mill St, Dearborn MI 48179	Father	100 total must equal 100%

4.0 Other Insurance

Does the proposed life insured currently have life, accidental death, critical illness or disability income insurance in force? Yes No
If "Yes", please fill in the information below. Also include information about Foresters life insurance certificate(s).

Name of Insurer.	Life Insurance \$	Accidental Death \$	Critical Illness \$	Disability Income \$	Issue Year

Is there another life insurance application pending for the proposed life insured with Foresters or another insurer? Yes No
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
If "Yes", complete the required, State and Foresters, replacement/rollover/surrender/disclosure forms. Include existing life insurance or annuities in the process of being lapsed or surrendered, and those completed within the past 13 months.
If "Yes" to either of the two questions above, enter the details.

5.0 Medical Information.

Proposed life insured's:

5.1 a) Height is? 6' 2" inches b) Weight is? 180 lbs
c) Has there been an increase or decrease of more than 10% in weight in the last 12 months? If "Yes", state the reason and the amount of weight increase or decrease.

5.2 Primary care physician or medical practitioner is?
Name: Dr. Brown
Address: 7 Pine Blvd., Dearborn MI

5.3 a) Date of last consultation with a physician/medical practitioner: Jan/31/2006
b) Reason for, and result of, consultation was? Fitz's Test

c) Last consultation was with primary care physician/medical practitioner named in 5.2 above? Yes No
If "No", the last consultation was with the following physician/medical practitioner:
Name: _____ Phone number: (____) _____ - _____
Address: _____

770197 AZ 01/08 Page 2 of 10

Indicate reasons for and results of last doctor's visit.

Sections 6 & 7: Medical and Personal History

If there is a circle in this column, additional questionnaire(s) will be required if the answer to that question is 'Yes'.

7.1 Presently taking prescription medication? Yes No Required Supplemental Form Completed

7.2 Presently under treatment? Yes No

7.3 Had medication, treatment or a diagnostic test prescribed or advised that has not yet been started or completed? Yes No

7.4 In the past 10 years, had an exercise ECG, echocardiogram or other ultrasound, angiography, CAT or MRI scan, biopsy, endoscope, or other special screening or diagnostic test? Yes No

7.5 In the past 10 years, been diagnosed as having, or received treatment for:

a) High blood pressure, stroke, transient ischemic attack (TIA), swelling of the ankles, shortness of breath, chest pain, pressure or discomfort, angina, aneurysm, leg pain, disorder of the arteries, heart attack or murmur, irregular heartbeat, or other disorder of the heart or circulatory system? Yes No

b) High levels of cholesterol or triglycerides in the blood? Yes No

c) Anemia, swollen glands or other disorder of the blood or lymphatic system? Yes No

d) Cancer, tumor, polyp, cyst, abscess, unexplained swelling or lumps? Yes No

e) Auto-immune disease or other disorder of the immune system (other than HIV)? Yes No

f) Asthma, emphysema, chronic cough, sleep apnea, coughing of blood, or other disorder of the nose, throat or lungs? Yes No

g) Chronic hepatitis, pancreatitis, diarrhea, indigestion, colitis, ileitis, abdominal pain, bleeding, bowel obstruction or chronic disease of the esophagus, stomach, gall bladder, pancreas, liver, or bowels? Yes No

h) Chronic kidney disease, kidney stones, an incident of blood in the urine, or a disorder of the bladder, kidney, prostate gland or reproductive organs? Yes No

i) A seizure, convulsion, epilepsy, paralysis, multiple sclerosis, or chronic disorder of the nervous system, brain, eyes or ears? Yes No

j) Depression, anxiety, schizophrenia or other psychiatric disorder? Yes No

k) Arthritis or other chronic disorder of the joints, bones, muscles, skin or connective tissues? Yes No

l) Diabetes or other disease of the pancreas, thyroid, pituitary or other endocrine glands? Yes No

7.6 Consulted with another physician/medical practitioner, other than identified in 5.2 or 5.3, in the past 5 years? Yes No

7.7 Ever tested positive for HIV (Human Immunodeficiency Virus) as part of a test for obtaining insurance? Yes No

7.8 Within the past 5 years applied for or received, from any source, waiver of premiums, disability income or a critical illness benefit? Yes No

7.9 Had/Have a parent and/or sibling with a history of diabetes, heart attack, angina, stroke, cancer, polycystic kidney disease, Huntington's Chorea, Alzheimer's, ALS (Amyotrophic Lateral Sclerosis) or other hereditary disorder? Yes No
(If 'Yes', specify the parent and/or sibling, condition and age at onset in number 7.10). (For cancer, specify type.)

7.10	Age if living.	Age at death.	Details of condition/ Cause(s) of death.	Sibling	Age if living.	Age at death.	Details of condition/ Cause(s) of death.
Father	65			Sibling			
Mother	63			Sibling			

7.11 Provide details to all 'Yes' answers to questions 7.1 through 7.8.

Question number.	Condition or disease, diagnosis as advised by attending physician, treatment, present condition.	Dates of onset/ recovery. (mm/dd/yyyy)	Physician's name, address and phone number.
7.4	ECG as part of fitness test.	Nov/22/2008	Dr. Brown, 7 Pine Blvd.,

770197 AZ 01/08

Provide details to all 'Yes' answers in the space provided. Attach additional paperwork if necessary.

Medical and Personal History:

- ❑ Ask each question exactly as worded and record each answer as given by the proposed life insured (even if you know or suspect that a given answer is incorrect. If this happens, alert the underwriter on the Producer Report or in a cover letter)
- ❑ Recording an accurate and complete health history is extremely important for expediting the underwriting process. Partial or vague declarations often raise more questions which may cause delays in processing the application

Tobacco/Nicotine Use:

- ❑ Smoking status is based on the date that the proposed life insured last used cigarettes or marijuana

Sections 8 & 9: Billing and Payment Information & TIA Acknowledgement

8.0 Billing and Payment Information.

Payer Is: Proposed life insured Owner Other (Supplemental form required.)

Pre-authorized check plan: Monthly Quarterly Semi-annually Annually

Direct Bill: Quarterly Semi-annually Annually

It is acknowledged and agreed that Foresters may change the payment modes and/or payment methods available for premium payments after a certificate comes into effect, if issued in response to this application.

How the pre-authorized check plan works: Pre-authorized checking is a debit service that provides a convenient way to make payments. If elected, pre-authorized checking allows Foresters to collect payments, by making deductions from the payer's bank account electronically on pre-determined dates, eliminating the need for checks to be written or payments to be submitted by mail. The payer should confirm deductions made from their account by reviewing the financial institution's records of their account transactions as these records will be considered receipts for payments made.

Request for Pre-Authorized Check Plan ('PAC plan')
The payer agrees, as evidenced by his or her initials below and signature in the Signature Section of this Application, that the following terms and conditions apply:

- Foresters is authorized to draw deductions under the PAC plan from the account identified in the banking information below or another account later identified or substituted by the Payer.
- The financial institution from which payments are to be withdrawn is authorized to treat each withdrawal by Foresters as though it was made personally by the payer.
- Deductions will be drawn in or before the month the payment is due, however Foresters reserves the right to determine when the first deduction, if any, will be made and the amount of that deduction.
- This PAC plan is effective immediately and will continue until terminated by the payer. The payer must submit a written request to terminate this PAC plan to the other specifying the termination date.
- The PAC plan may be terminated immediately or at any time by the payer. Failure to terminate this PAC plan will constitute the payer's agreement to the terms and conditions of this PAC plan. The right to terminate the PAC plan as set out in this authorization of Foresters is not affected by the termination of this application.

To combine payments under this PAC plan with a currently active Foresters policy, the payer must provide the following information:

Banking information is to be taken from: Attached void check Check stub Information supplied below (required if not attached)

Bank account type: Checking Savings

Financial institution's name: _____

Financial institution's address: _____

City: _____ State: _____ Zip code: _____

Transit number: _____ Account number: _____

Payer acknowledges that payments may be deducted from his/her bank account. (Payer's initials) _____

Consent and Questions.

No effect. JD (Payer's initials)

9.1 Within the past 120 days, been admitted to a hospital or other licensed health care facility (other than for childbirth)? Yes No

9.2 Within the past 120 days, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)? Yes No

9.3 Within the past 120 days, had surgery performed or recommended, had or been medically advised to have a medical test or investigation which was refused to be undertaken, has not yet been undertaken or the results of which are still unknown? Yes No

First payment, in the amount of \$ 100.00, is being provided by: Check/Bank Draft/Money Order Pre-authorized check plan No first payment provided (TIA Agreement not terminated)

770197 AZ 01/08

Payer's initial is required for PAC plans

TIA pre-conditions not met: Check 'No' and obtain the owner's initials.

If 'Pre-authorized check plan (PAC)' is selected then the first payment amount must be the planned modal premium.

Premium and Billing Information:

- Pre-authorized Check Plan (PAC) is available on a monthly, quarterly, semi-annual and annual basis
- Direct billing is only allowed on a quarterly, semi-annual and annual basis

Temporary Life Insurance

- Provides temporary life insurance up to \$500,000 if the following pre-conditions are met:

- All TIA questions are answered 'No' and these answers are truthful
- Monthly premium is given to the producer no later than the application date
- Total coverage applied for (including all riders payable upon death, e.g. ADR and Charity rider) is less than or equal to \$1,000,000
- Proposed life insured younger than age 71

Section 10: Agreements

10.0 Agreements

"I/Me" means individually each person identified in this Application as either the proposed life insured or the owner, and the parent/ legal guardian signing this Application if the proposed life insured is a juvenile. I, as evidenced by my signature in the Signature Section of this Application, have read, understand, agree, and declare:

1. I have read this Application. I was asked every question that applies to me and provided the answers shown, in this Application, to these questions. The statements, answers, and representations contained in this Application are full, complete, and true. All statements made in this Application shall be representations and not warranties.
2. No person, including a producer, has the authority to waive the disclosure of full, complete and truthful information in response to each question in this Application. Such person also has no authority to write down an answer given to a question in this Application other than the answer that was provided to the producer.
3. Medical examination report(s) that may be required by Foresters shall form part of this Application. I will provide full, complete and true answers required in a medical examination report(s). This Application, Foresters Instruments of Incorporation and its Constitution now in force or subsequently enacted shall form part of the entire contract with Foresters.
4. The insurance contract that Foresters issues, if at all, as a result of this Application, is conditional on there being no change in the insurability of the proposed life insured, or a child identified in this Application, if any, between the date of this Application and the date the certificate is delivered to the owner. The insurance contract issued in response to this Application, if any, comes into effect, if at all, as described in that insurance contract. Changes or corrections made to this Application by Foresters, if any, are ratified by the owner when the insurance contract issued in response to this Application, if any, comes into effect.
5. A payment provided to Foresters is not paid to Foresters unless and until the payment is honored by the financial institution of the account from which the payment is to be drawn.
6. The answers, statements and representations contained in this Application will influence the assessment and acceptance of this Application by Foresters. Failure to disclose all material facts may result in a loss of coverage and cancellation of the insurance contract. It is understood and agreed that these declarations are used to establish the premium rate of the insurance provided, if any, and that a material misrepresentation or untrue declaration may render the insurance contract issued, if any, voidable. All facts should be shown in this Application.
7. No producer, medical examiner or any other person, except Foresters Executive Secretary or successor position, has power on behalf of Foresters to do either a) or b).
 - a) make, modify, or discharge an insurance contract; or
 - b) bind Foresters by making promise(s) regarding the future performance or benefit(s) of an insurance contract issued other than as specifically written in the insurance contract issued, if any, as a result of this Application.
8. 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 subjects such person to criminal and civil penalties. In addition, Foresters may deny payment of insurance benefits if false information materially related to a claim was provided by the proposed life insured or owner.
9. The terms of the temporary coverage provided, if any, are set out on pages 9 and 10 of this Application, including the pre-conditions and special limitations to temporary coverage and the amount and duration of that temporary coverage.
10. This Application is subject to and governed by the laws of the State where this Application was delivered to the owner, if an insurance contract is issued in response to this Application.
11. If the amount of a first payment submitted with this Application, by selected mode, is more than the amount of the first modal premium required for the certificate, if any, that comes into effect in response to this Application, the difference between those two amounts will be held by Foresters and applied, without interest, to the next modal premium or, at Foresters option, refunded without interest.
12. This Application, and related documents, may be sent to Foresters by electronic means, including, but not limited to, e-mail and facsimile transmission.
13. Foresters may send, to an e-mail address provided to us, if any, information about this Application, a certificate issued as a result of this Application, if any, Foresters and Foresters membership, including member benefits and events.

Agreements:

- Proposed life insured, owner (if other than then proposed life insured) and parent and/or legal guardian (if juvenile application), must read and understand the agreements

Section 11: Authorization to Obtain & Disclose Information

Signature Requirements:

- Proposed life insured, payer and owner (if the proposed life insured is a juvenile or not the owner), must read and sign this page
- Juvenile applications: if the applicant is not the child's parent or legal guardian, in the Producer Report indicate:
 - Relationship of the child and the applicant
 - Purpose of the insurance
 - How often the applicant sees the child (i.e. can the applicant attest to the child's health history)
 - Do the parents and/or legal guardian have knowledge of the insurance purchase and have they agreed to it
 - A parent's and/or legal guardian's signature may be required

11.0 Authorization to Obtain and Disclose Information.

In this authorization, proposed life insured means the proposed life insured identified in this Application. Child means each 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 life insured, and owner, on their own behalf and on behalf of each child, authorizes Foresters and its reinsurers to obtain information about the proposed life insured and each child from any physician, medical practitioner, hospital, clinic, or medical facility; employer; other insurer or institution; consumer reporting agency; pharmaceutical reporting database; or Medical Information Bureau, Inc. ("MIB, Inc.).

Foresters may obtain an investigative consumer report and records or other information available as to past, current or future diagnosis, treatment and prognosis of a physical or mental condition.

Foresters may obtain past, current or future drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. As it pertains to alcohol and drug information covered by federal regulation, this may be revoked at any time by written notice to Foresters. All action taken by Foresters before written revocation will not be affected.

Foresters may make a brief report to MIB, Inc. about the proposed life insured and those who perform services for Foresters related to an application for insurance. If the proposed life insured has applied for or may apply for life or health insurance, or benefits, this authorization shall be the consent required, whether implied or express, written or oral, for the collection, retention, usage and disclosure of such information. This authorization is valid for two and one-half years from the date of this original document or a copy of this authorization to obtain information. A copy of this authorization will be provided upon request.

12.0 Signature Section.

Signature of proposed life insured (if the proposed life insured is not a juvenile): John Doe

Signature of owner (if other than proposed life insured): _____

Signature of parent/legal guardian (if the proposed life insured is a juvenile and the parent/legal guardian is not the owner): _____

Signature of payer (if other than owner or proposed life insured): _____

Each person signed on: Jul13/2007
(mm/dd/yyyy)

New certifications:

- Solicitation and sale to active duty members (US military)
- Electronic transmittal

Producer's signature required

asked all questions as written in this Application and have recorded all answers.

If applicable, I have fulfilled all State and Federal requirements regarding the sale of life insurance to active duty members of the United States military.

If applicable, I have disclosed that this Application will be transmitted to Foresters by electronic means and that this original Application will be destroyed after successful transmission has been confirmed.

This Application has not been altered in any way after the proposed life insured and owner, if other than the proposed life insured, signed it.

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

Producer: Jim Jackson Print full name.

Jim Jackson Signature.

12345 Producer number.

Signed at: _____ City, State

Signed on: Jul13/2007
(mm/dd/yyyy)

770197 AZ 01/08 Page 7 of 10

Section 12: Notice of Information Procedures

13.0 Notice of Information Procedures.

This page must be given to the proposed life insured.

For purposes of this Notice the following words and phrases are defined. The word "Application" means the Application for Individual Life Insurance to which this Notice relates. "Producer" means the licensed individual who signed that Application as the producer. "We", "our", and "us" mean The Independent Order of Foresters. "You" and "your" mean individually the proposed life insured, and each child, if any, identified in that Application.

Privacy
Personal information we obtain about you is confidential. As permitted by privacy laws, we may disclose information without further authorization. This includes disclosure to consumer reporting agencies hired to prepare investigative reports and insurance companies to which you have applied for coverage or benefits. It also includes those providing services for us and those conducting bona fide actuarial, marketing or scientific studies or audits. We may also disclose information to your physician and The Medical Information Bureau ("MIB, Inc."). Upon written request to us we will give you more information about these procedures.

You can make a written request to review personal information about you in our certificate file. However, we will not disclose information to you that was prepared for an anticipated claim or civil or criminal proceeding. You may request a correction, amendment or deletion of the information in our files which you believe to be inaccurate or irrelevant. Upon written request, we will provide you with further information about these procedures.

Medical and Personal Information
The Underwriting process evaluates information about you to see if you qualify for the insurance you requested. The information we review may vary with the insurance applied for. We consider information about you such as your age, occupation, and health. We also consider your mode of living, avocation and other personal information.

The answers in this Application are our principal source of information. We may contact other people or institutions personally, by phone or by letter, to confirm or add to the information provided in this Application. For example, we may obtain information from a doctor, clinic, hospital, other insurers, or a lending institution. In some cases, a producer or other Foresters representative may obtain information for us. A medical examination or laboratory tests may be requested.

In some cases, we may contact you, your neighbors, friends or others you know. You may request a personal interview with the agency to discuss this information. If you do not wish to be interviewed, you may request that we not contact you. We will attempt to contact you only if you have given us your consent.

If we order an Investigative consumer report, it may include information obtained through interviews with your neighbors, friends or others you know. You may request a personal interview with the agency to discuss this information. If you do not wish to be interviewed, you may request that we not contact you. We will attempt to contact you only if you have given us your consent.

Members who have a business need for it, MIB, Inc. may provide us or our reinsurers with a brief report about you. Upon your written request, MIB, Inc. will arrange for disclosure of information it may have in its file about you. If you question the accuracy of MIB, Inc.'s information, you may request a correction according to the procedures in the Federal Fair Credit Reporting Act. Send these requests to MIB, Inc., PO Box 105, Essex Station, Boston, Massachusetts 02112. Their phone number is 866 692 6901.

If we order an Investigative consumer report, it may include information obtained through interviews with your neighbors, friends or others you know. You may request a personal interview with the agency to discuss this information. If you do not wish to be interviewed, you may request that we not contact you. We will attempt to contact you only if you have given us your consent.

Foresters, Chief Underwriter
789 Don Mills Road
Toronto, Canada M3C 1T9

US Mailing Address
PO Box 179
Buffalo, NY 14201-0179

Producer name Jim Jackson Office phone number 712-744-5000

770197 AZ 01/08 Page 8 of 10

Notice of Information Procedures:

- The proposed life insured must read this page
- Leave this page with the proposed life insured
- This page:
 - Contains the notice of information procedures and Foresters contact information
 - States Foresters privacy policy, underwriting process and Medical Information Bureau (MIB) information
 - Gives a description of some of the additional sources of underwriting information (the proposed life insured consents to the release of this information to the MIB by signing the authorization to obtain and disclose information page). If the proposed life insured requires further information about MIB or their record with them, they should contact MIB directly at the address provided on this page

Section 14: Temporary Life Insurance Agreement

Temporary Life Insurance Agreement (TIA)

14.0 Temporary Life Insurance Agreement (TIA) (e.)

Definitions.
For purposes of this Temporary Life Insurance Agreement, "Producer" means the person identified as the proposed life insured in the Application. "Owner" is identified in the "Owner" section of 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:

- The proposed life insured is not age 71 or older on the date the Application is signed by the owner.
- No more than \$1,000,000 insurance coverage on the life of the proposed life insured is applied for in the Application, calculated by including the amount of the benefit applied for under a rider (except common carrier accidental death coverage if any) payable in the event of death of the proposed life insured.
- All questions in this Agreement are answered 'No' and the 'No' answers shown to the questions in this Agreement are truthful.
- No later than the date the Application is signed by the owner, a first payment, in an amount equal to at least a monthly premium for the insurance applied for in the Application, is provided.

If either one or more of the above pre-conditions are not met, no temporary coverage takes effect under this Agreement even if the Agreement was left with the owner.

Temporary Life Insurance Agreement Questions.
Has the proposed life insured:

1. Within the past 24 months, had either an investigation or treatment, or both, by a physician or medical practitioner for chest pain, heart problem, stroke or cancer?	Yes No
2. Within the past 120 days, been admitted or been medically advised to be admitted to a hospital or other licensed health care facility (other than for childbirth)?	Yes No
3. Within the past 120 days, had surgery performed or recommended, had or been medically advised to have a medical test or investigation which was refused to be undertaken, has not yet been undertaken or the results of which are still unknown?	Yes No

• First payment, in the amount of \$ 100.00, is provided by:
 Check/Bank Draft/Money Order Pre-authorized check plan (PAC) Other _____ (Specify):
 No first payment provided (TIA Agreement must be left with owner).

Amount of Temporary Coverage.
Subject to the terms of this Agreement, if all pre-conditions are met and the proposed life insured dies while this Agreement is in effect, Foresters shall pay, to the beneficiary named in the Application, under this and all other Foresters temporary life insurance agreement(s) insuring the life of the proposed life insured:

- The amount of insurance applied for in the Application, including the amount payable for common carrier accidental death coverage, if any; or
- \$500,000.

Termination of Temporary Coverage.
Subject to the terms of this Agreement, the temporary coverage shall terminate on the date of no further force of effect:

- Ninety (90) days after the date the Application is signed by the owner.
- The date an application for permanent life insurance is issued in response to the Application.
- 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.
- The date a written or oral request to withdraw the Application is made by or on behalf of the proposed life insured or the owner.
- The date a written or oral request to terminate this Agreement is made by or on behalf of the proposed life insured or the owner.
- The date written notice is sent by Foresters, as shown in Foresters records, to the proposed life insured or the owner, terminating this Agreement.
- The date written notice is sent by Foresters, as shown in Foresters records, to the proposed life insured or the owner, declining the Application.

770197 AZ 01/08 Page 9 of 10

TIA pre-conditions met: Leave TIA with the owner.

If 'Pre-authorized check plan (PAC)' is selected then the first payment amount must be the planned modal premium.

If Pre-conditions Met:

- TIA to be left with the owner

If Pre-conditions Not Met:

- Do not leave the TIA with the owner
- Do not submit these TIA pages to Foresters
- Do not collect 'cash with application'
- Check 'No', the TIA was not left with the owner and obtain the owner's initials on page 5 of the base application

Supplemental form: Contingent Owner/Other Payer form

The Independent Order of Foresters ("Foresters")
789 Don Mills Road
Toronto, Canada M3C 1T9

U.S. Mailing Address:
P.O. Box 179
Buffalo, NY 14201-0179

www.foresters.com
T. 800 828 1540

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Contingent Owner/Other Payer Identification Form

For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner."

Proposed Life Insured:
First name: _____ Middle name: _____ Last name: _____

Contingent Owner Information

Address Line 1: _____
Line 2: _____

Contingent owner is an individual.
First name: _____ Middle name: _____ Last name: _____
 Male Female Date of birth: _____ Birth state: _____ Birth country: _____
Home phone number: (____) _____ - _____ Social security number: _____
Relation to proposed life insured: _____
Photo I.D. used to verify identity and birth date:
 Driver's license number and state: _____
 Passport Other government I.D.: _____
A citizen of the United States? Yes No If "No", what is the country of citizenship? _____

If the contingent owner is other than an individual, it is a: _____
Entity/Trust name: _____
If owner is a trust: Date of trust agreement: _____
Name and address of trustee: _____

Other Payer Information. (Complete this section to identify a payer other than the proposed life insured or the owner.)

Address Line 1: _____
Line 2: _____ City: _____ State: _____

First name: _____ Middle name: _____ Last name: _____
 Male Female Date of birth: _____ Birth state: _____ Birth country: _____
Home phone number: (____) _____ - _____ Social security number: _____
Employer's name: _____ Employer's phone number: (____) _____ - _____
Employer's address: _____
Relation to proposed life insured: _____
Photo I.D. used to verify identity and birth date:
 Driver's license number and state: _____
 Passport Other government I.D.: _____
A citizen of the United States? Yes No If "No", what is the country of citizenship? _____

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

Signature of proposed life insured: _____ Signature of owner (if other than proposed life insured): _____
Producer's name (print full name): _____ Producer number: _____
Producer's signature: _____
Each person signed at: _____ (City, State) Each person signed on: _____ (mm/dd/yyyy)

104907 US 01/08 Page 1 of 1

Contingent Owner

- If the owner dies, the contingent owner becomes the owner
- A Contingent Owner form should only be completed if the proposed life insured is not the owner and a contingent owner is to be named

Supplemental form: Children's Term Rider form

The Independent Order of Foresters ("Foresters")
789 Don Mills Road
Toronto, Canada M3C 1T9

U.S. Mailing Address:
P.O. Box 179
Buffalo, NY 14201-0179

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Children's Term Coverage – Application Form

For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner.

Proposed Life Insured:
First name: John Middle name: Chris Last name: Doe

Child(ren)'s Information (Must be under 18 years of age at time of application)

1.	Name of child(ren) proposed for insurance (first, middle, last)	Relationship	Date of Birth (mm/dd/yyyy)	Age
1.	<u>Andy Peter Doe</u>	<u>son</u>	<u>2007/07/23</u>	<u>9</u>
2.				
3.				
4.				

Child(ren)'s Medical History (Applies to each child listed above.)

(*Treatment* includes the professional services of a therapist, medical practitioner, physician, medical professional or practitioner of alternative medicine and also includes a weight loss or control program.)

Question	Yes	No	Required Supplemental Form Completed
1.0 Is a child presently taking medication or undergoing treatment?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
2.0 Has a child had medication, treatment or a diagnostic test prescribed or advised that has not yet been started or completed?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
3.0 Has a child been diagnosed with or treated for an acquired or congenital disorder of the lungs, heart, arteries, blood, kidneys, brain, spinal cord, nerves or muscles?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
4.0 Does a child have a history of any of the following?			
a) Hyperactivity and/or attention deficit disorder or other behavioral disorder?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
b) Fetal alcohol syndrome or Down syndrome or other genetic disorder?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
c) Anorexia, bulimia, or a suicide attempt?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
d) Testing positive for HIV (Human Immunodeficiency Virus) as part of a test for obtaining insurance?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
e) Cancer, seizures, chronic hepatitis B or C, diabetes?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>

Provide details to all "Yes" answers 1.0 through 4.0.

Question number	Child's name	Condition or disease, diagnosis as advised by attending physician, treatment, present condition.	Dates of onset/recovery (mm/dd/yyyy)	Physician's name, address and phone number.

I understand that this Children's Term Coverage - Application Form is part of and is subject to the Application.

Signature of proposed life insured: John Doe
Signature of owner (if other than proposed life insured): _____
Producer's name (print full name): Jim Jackson
Producer's signature: Jim Jackson
Producer number: 12345

Each person signed at: Dearborn, MI (City, State) Each person signed on: Jul/13/2007 (mm/dd/yyyy)

770247 US 01/08 Page 1 of 1

Children's Term Rider

- Complete only if applying for Children's Term Rider (CTR)
- Do not submit this page to Foresters if not applied for

Supplemental form: Disability Income Rider form

The Independent Order of Foresters ("Foresters") U.S. Mailing Address: www.foresters.com
789 Don Mills Road P.O. Box 179 T. 800 626 1540
Toronto, Canada M3C 1T9 Buffalo, NY 14201-0179

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Disability Income Coverage – Application Form (Where required, complete appropriate coverage disclosure form(s).)

For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, "you" and "your" mean the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner.

Proposed Life Insured:
First name: John Middle name: Chris Last name: Doe

Employment Information: Number of hours currently employed per week? _____ Number of weeks currently employed per year? _____
Is your employment scheduled to end, or have you received notice that it will end, within the next 26 weeks? Yes No
If "Yes", how long have you held that employment? _____
Is your current occupation seasonal or temporary work? Yes No
(Seasonal or temporary work means employment that is less than 26 weeks in duration during a period of 52 consecutive weeks.)

Questions.

1.0 In the past 6 months, have you been working full-time (minimum of 30 hours per week) and performing each and every duty of your regular occupation in the usual and customary manner? Yes No

2.0 For what percentage of time each week do you perform special duties such as overtime, washing, or lifting items greater than 20 lbs., or _____ %

3.0 Are you or under _____

4.0 Within the _____ or either

5.0 Do you use of _____

6.0 Within the _____ actionner _____

7.0 Do you _____ activities _____

8.0 Do you have any _____ of the duties _____

9.0 In the past 3 years have you _____ form, for more than 5 consecutive work days, any of the duties _____

10.0 Your gross income from employment _____ 12 month period immediately preceding the date of this Application was? \$ _____

Provide details to all "Yes" answers to questions 3.0 through 9.0.

Question number	Details

I understand that this Disability Income Coverage - Application Form is part of _____
Signature of proposed life insured: John Doe
Producer's name (print full name): Jim Jackson
Producer's signature: Jim Jackson
Each person signed at: Dearborn, MI (City, State)

770246 US 01/08

Disability Income Rider

- Complete only if applying for the rider
- Additional disclosure forms may be required
- Do not submit this page to Foresters if not applied for

If the answer to any question 3-9 is 'yes', please provide the details in this section

Proposed life insured's gross income is one of the factors used to determine the monthly maximum Disability Income amount.

Supplemental form: Critical Illness Rider (Accelerated Death Benefit)

The Independent Order of Foresters ("Foresters")
789 Don Mills Road
Toronto, Canada M3C 1T9

U.S. Mailing Address:
P.O. Box 179
Buffalo, NY 14201-0179

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T. 800 828 1540

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Critical Illness Coverage – Application Form (Where required, complete appropriate coverage disclosure form(s).)
For purposes of this form, "Application" means the Application for Individual Life Insurance on the proposed life insured, "you" and "your" mean the proposed life insured, and "I" means individually each person identified in the Application as either the proposed life insured or the owner.

Proposed Life Insured:
First name: _____ Middle name: _____ Last name: _____

Questions.

	Yes	No
1.0 Have you ever been diagnosed with or treated by a physician or medical practitioner for cancer, diabetes, heart attack, stroke, transient ischemic attack (TIA), end-stage kidney disease, organ transplant, paralysis, loss of 2 or more limbs, or blindness?	<input type="radio"/>	<input type="radio"/>
2.0 Are you currently receiving a benefit under a type of disability insurance (including a governmental plan) or under the critical illness provisions of an insurance contract?	<input type="radio"/>	<input type="radio"/>
3.0 Within the last 12 months, have you filed a claim with a governmental program or insurance company for either disability benefits or benefits on account of a critical illness?	<input type="radio"/>	<input type="radio"/>

Provide details to all 'Yes' answers to questions 1.0 through 3.0.

Question number	Details

I understand that this Critical Illness Coverage - Application Form is part of and is subject to the Application.

Signature of proposed life insured: _____ Signature of owner (if other than proposed life insured): _____

Producer's name (print full name): _____ Producer number: _____

Each person signed at: _____ (City, State) _____ Each person signed on: _____ (mm/dd/yyyy)

770245 US 01/08 Page 1 of 1

Available with Strong Foundation only

Critical Illness Coverage

- Complete only if the proposed life insured is applying for this rider
- Additional disclosure or illustration forms may be required
- Do not submit this page if not applied for
- Ensure details to all 'Yes' answers to questions 1.0 through 3.0 are provided where indicated. Attach additional pages and/or paperwork if necessary. Ensure all additional pages are signed and dated by the owner.

Contact Information

Shipping Instructions

- Mail/Courier application to NAA Home Office

For more information

- Foresters Sales Desk: 1-877-622-4249 (1 877 NAA 4Biz)

In order to receive electronic applications for your state please email paperwork@naarep.com indicating for what state the applications are needed in.