



APPLICATION FOR REINSTATEMENT
 (PLEASE COMPLETE A, B, D,& E)

CHANGE
 (PLEASE COMPLETE A, C, D, E)

Application for Change/Reinstatement

A POLICY INFORMATION

Life Insured _____ Policy No. _____
 Date of Birth _____ Policyowner (if other than Life Insured) _____
 (Month/Day/Year)
 Address _____
 Occupation _____

B [] APPLICATION FOR REINSTATEMENT

Foresters Life Insurance Company is requested to reinstate this policy, in accordance with the policy provisions. Parts A, B D and E of this application are hereby completed in reference to such application for reinstatement.

C [] APPLICATION FOR CHANGE

Foresters Life Insurance Company is requested to change this policy and to make the necessary amendments as follows:

Please Check for box that applies:

- Review of Class
- Removal of Rating
- Application for Non-smoking Rates (smoking habits declaration must accompany form)
- Addition of Accidental Death Rider for \$ _____ the new premium will be \$ _____
- Addition of Waiver of Premium Benefit
- Addition of Child Rider Benefit for \$ _____ on the life of _____
(** Child Rider Application must accompany this form to be completed on Child's Life)
 This is available at ages 0 – 16 with the coverage running to age 25 for each child or age 65 of Life insured. This benefit expires when premium paying period ends, therefore this benefit may expire prior to child reaching 25. The minimum coverage amount is \$10,000 and the maximum is \$20,000.
- Addition of _____ Rider Benefit for \$ _____.

Additional Instructions _____

Foresters Life Insurance Company
 789 Don Mills Road, Toronto, Ontario M3C 1T9

T: 905-219-8000 TF: 800-267-8777 F: 905-219-8135 www.foresters.com



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D. Questions below must be answered by the Life Insured on all Reinstatements; Changes involving an increase in risk or addition of a benefit; where a benefit not in the original policy is being requested.

	yes	no	Details of YES answers. Identify by number.
1. Since applying for this policy have you:			
(a) engaged in, or intend to engage in any hazardous sport or activity flying as a pilot, sky diving, scuba diving, motor racing, etc.?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(b) had your driver's license suspended or have you had 2 or more moving violations in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
(c) had an application for insurance on your life declined, postponed or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>	_____
(d) any intention of changing your country of residence or taking an extensive journey?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Are other applications or negotiations for insurance on your life now pending or contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Is this insurance to replace or substantially change any other insurance now or recently held in this or any other company?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Since applying for this policy have you:			
(a) Had a checkup, consultation, illness, surgery, injury or disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
(b) Had an electrocardiogram, x-ray, blood or other diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>	_____
(c) Been a patient in a hospital, clinic or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	_____
(d) Ever used marijuana, cocaine or other illegal drugs or received Treatment or counselling for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. (a) Have you ever been treated for or ever had any known indication of A.I.D.S. (Acquired Immune Deficiency Syndrome), A.R.C. (A.I.D.S. Related Complex) or any other immunological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
(b) Within the past 5 years, have you had a test indicating exposure to the A.I.D.S. virus?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. (a) Have you smoked any cigarettes or cigarillos in the past 12 months? Average Daily Quantity _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(b) If you were a smoker but stopped, give date you last smoked. _____			_____
(c) Do you use other tobacco or nicotine based products? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Initials of Proposed Life Insured _____			
NOTE: Misstatement of smoking habits will render the contract Voidable.			

7. (a) Height and weight _____ ft. _____ Ins. _____ Lbs. _____ cms. _____ kilos

(b) Has your weight changed in the past year? Yes No Gain _____ lb/kilos Loss _____ lb/kilos

8. (a) Name and address of your personal physician? _____ (if none, so state)

(b) Date and reason last consulted? _____

(c) Was any treatment given or medication prescribed? Yes No
If yes, please provide full details? _____

I declare that the above answers and statements are complete and true.

Dated at _____ this _____ day of _____ 20 _____

Signature of witness (Unrelated Adult)

X _____
Signature of Life Insured

X _____
Signature of Policyowner (if other than Life Insured)

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E DECLARATION AND AUTHORIZATION

The policyowner has paid the company \$ _____ on account of the premium(s) for this reinstatement or change.

I declare and agree that:

1. All statements, representations and answers made in this application, together with any other additional evidence as may be required by Foresters Life Insurance Company, are true, full and complete, and are a consideration for and a basis of the reinstatements or change being requested.
2. If within two years from the date of reinstatement or change, either the life insured dies by suicide whether same or insane, or any of the said statements are found to be incomplete or untrue in any material respect, the reinstatement or change shall be voidable at the option of the Company.
3. Reinstatement shall take effect, if approved at Head Office, as at the date of the application or the date of settlement of the premium arrears, whichever is later.
4. Change or conversion shall take effect, if approved at Head Office, as at the date of such approval or the date of settlement or charges pursuant to the change of conversion, whichever is later.
5. Acceptance of a policy so changed or converted shall be ratification of any corrections, additions or changes made by the Company in the space entitled "Corrections and Amendments".

I acknowledge that I have received the notices regarding the Medical Information Bureau, Consumer Report, and the Personal History Interview Program.

I consent to a consumer report and/or personal interview containing personal information, or credit information or both that may be requested in connection with my applications.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Foresters Life Insurance Company or its reinsurer(s) any such information.

A photographic copy of this authorization shall be as valid as the original

Dated at _____ this _____ day of _____ 20 _____

Witness Signature _____
Signature of Life Insured

Witness Signature _____
Signature of Policyowner (if other than life Insured)

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Foresters Life Insurance Company

REQUEST FOR PRE-AUTHORIZED CHEQUE ("PAC") PLAN

I authorize Foresters Life Insurance Company to make monthly withdrawals from the following account or any account I may designate hereafter. I further authorize any Financial Institutions with whom I have an account to process such withdrawals as if I had personally signed such instruments of withdrawals are to pay premiums (including overdue premiums) and any other payments I may authorize from time to time for policies listed below and for any policies added at a subsequent date.

- I agree that:
- (1) the Pre-Authorization Cheque Plan will apply to policy premiums due on or after this authorization;
 - (2) this authorization may be cancelled by either party at any time on written notice to the other party;
 - (3) if this authorization is cancelled the unpaid balance of the yearly premium will be due immediately
 - (4) this authorization is given for use solely by Foresters Life Insurance Company and my financial institutions. The instrument used for withdrawal may be in the form of paper, magnetic tape, electronic or any other media as shall be agreed upon by Foresters Life Insurance Company and my Financial Institutions.

The Pre-Authorized Cheque Plan is for my convenience. The responsibility for payment of policy premiums, and any other payments authorized under this agreement, remains with me at all times and all payments made under the PAC Plan are subject to the provisions of the policy or policies.

PRINT NAME OF ACCOUNT HOLDER
AS ON ACCOUNT RECORDS

Name and Address of Financial Institution

..... Account No.

<input type="checkbox"/> New Request		<input type="checkbox"/> Addition to Existing Plan		
POLICY NO.(S)	NAME OF POLICYOWNER OR LIFE PROPOSED	AMOUNT OF PAC PAYMENT	AMOUNT OF LOAN REPAYMENT	WITHDRAWAL Date: <input type="checkbox"/> 1 st <input type="checkbox"/> 8 th <input type="checkbox"/> 15 th <input type="checkbox"/> 22 nd
				FOR H.O. USE: AUTHORITY NO.

DATE Signature as it appears on account records

NOTE: TO ENSURE ACCURACY, PLEASE ENCLOSE A SPECIMEN OF YOUR CHEQUE MARKED "VOID".

.....
For a joint account, all depositors must sign if more than one signature is required on cheques issued against the account

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RECEIPT

Any payment must be made payable to Foresters Life Insurance Company.

The sum of \$ _____ has been received from _____ as payment in connection with the application for

Reinstatement Change

Of Policy No. _____ issued on the life of _____

Foresters Life Insurance Company may deposit or cash this payment without prejudice to its right to refuse any reinstatement or change. If the company refuses the application for reinstatement or change, this payment shall be refunded.

FORESTERS LIFE INSURANCE COMPANY

THIS NOTICE MUST BE DETACHED AND GIVEN TO THE LIFE INSURED

NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. We, or our reinsurers may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information office is 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7, Telephone Number (416) 597-0590.

We, or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted..

NOTICE OF CONSUMER REPORT

This is to inform you that as part of our procedure for processing your application, a consumer report may be prepared whereby information is obtained through personal interviews with your neighbours, friends, or other with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

NOTICE OF PERSONAL INTERVIEW PROGRAM

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered as confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient to you.

Inquiries on the above notices should be addressed to:

Foresters Life Insurance Company
Underwriting Department

789 Don Mills Road
Toronto, Ontario
M3C 1T9

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