GENERAL PROVISIONS

DEFINITIONS

The terms defined below have the specific meaning shown when used in this policy. Additional definitions may be provided in the provisions of this policy or the amendments and riders, if any, attached to it. If the same term appears in an amendment or a rider it has the same meaning unless there is another definition for that term within that amendment or rider. When a provision is referred to in this policy we mean, unless specifically stated otherwise, the provision in this policy with that title. When a provision is referred to in a rider we mean, unless specifically stated otherwise, the provision in that rider with that title.

"**Age**" means the issue age plus the number of completed policy years.

"**Application**" means the application that was completed and signed for this policy and each rider, if any, that is attached to this policy.

"**Artificial Life Support**" means under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

"Attached Rider" means each rider, if any, listed in the Benefit and Premium Information Schedule.

"**Benefit Amount**" means the amount shown in the Benefit and Premium Information Schedule as the benefit amount, unless changed as shown in our records.

"**Covered Condition**" means a condition, disorder, illness, or surgical procedure that is described in the Covered Conditions provision.

"**Issue Age**" means the insured's age on their birthday nearest the policy date. The issue age is shown in the Benefit and Premium Information Schedule.

"Lapse" means the termination of this policy for non-payment, prior to the expiration of the grace period, of a total premium in default.

"**Insured**" means the person who is insured under this policy, as shown in the Benefit and Premium Information Schedule.

"**Insurer**", "**We**", "**Us**" and "**Our**" mean Foresters Life Insurance Company.

"**Monthly Anniversary**" means the same day of the month as the policy date for each succeeding month that this policy remains in effect.

"Moratorium Period" is the period of time that begins on the later of the date this policy takes effect and the effective date of the last reinstatement, if any, of this policy, and ends 90 days after it begins.

"**Physician**" means an individual who is legally licensed to practice medicine or surgery in Canada, the United States or another jurisdiction that we may approve, and who is acting within the scope of that license. The physician cannot be you or the insured, or a relative or business associate of either of you or the insured.

"Policy" consists of each numbered page, starting with page 1 and ending with the last provision of the Statutory Conditions.

"**Policy Anniversary**" means the same day and month as the policy date for each succeeding year that this policy remains in effect.

"**Policy Date**" is the date from which policy anniversaries, policy years and premium due dates are determined. The policy date is shown in the Benefit and Premium Information Schedule.

“Policy Year” is the period of time that, for the first policy year, begins on the policy date and ends on the day before the first policy anniversary, and, for every other policy year, begins on a policy anniversary and ends on the day before the next policy anniversary.

“Rider” means each attached rider, if any, and each rider added as an attachment, if any, to this policy after the policy date, as shown in our records.

“**Specialist**” means a physician who has been trained in the specific area of medicine relevant to the covered condition for which a benefit is being claimed, and who has been certified by a specialty examining board. In circumstances where a specialist is unavailable we may, at our discretion, accept a diagnosis made by a qualified physician.

“**Survival Period**” is the period of time that begins on the date that the insured is diagnosed with, or undergoes, a covered condition and ends 30 days later. Survival period does not include the number of days the insured is on artificial life support.

“Survived” means alive and living without being on artificial life support. The insured will no longer be considered to be alive on the date that they experience irreversible cessation of all brain functions, as determined by generally accepted medical criteria.

“**You**” and “**Your**” mean the owner shown in the Benefit and Premium Information Schedule of this policy, subject to change as described in the Ownership provision.

THE CONTRACT – The contract includes: (1) the application, together with all other documents authorized by the insured and submitted to us as evidence of insurability; (2) this policy; (3) each rider, if any, or other document attached to this policy and, (4) each amendment, if any, agreed to by us in writing.

If we fail to enforce a term or condition of the contract, we still retain our right to enforce all terms and conditions in the future. No agent or person, other than an authorized officer of Foresters Life Insurance Company, has the authority to waive or agree to change a condition or provision of the contract. A change to the contract must be in writing and signed by at least one of our officers authorized for that purpose. We will not be bound by a promise or representation heretofore or hereafter made by or to any agent or person other than as specified above.

WHEN THIS POLICY IS IN EFFECT – This policy takes effect on the policy date shown in the Benefit and Premium Information Schedule only if: (1) this policy has been delivered to you; (2) the first total premium was provided to us on or before the date this policy was delivered to you and that payment is honoured by the financial institution from which it is to be collected; (3) there has been no change in the insurability of the insured between the date the application was signed by the insured and the date this policy was delivered to you; and (4) when required by us, you accept, and if applicable sign and return to us, each amendment, addendum and exclusion, if any, required for the policy to take effect.

Once in effect this policy will remain in effect until the earliest of the following dates:

a) The date that a second benefit is paid under this policy;
b) The policy anniversary on which the insured is age 75;
c) The date the insured dies;
d) The effective date, as shown in our records, of your request to cancel this policy; or
e) The date this policy lapses, as described in the Grace Period provision.

This policy will not be in effect after the earliest of the above dates which means our liability under it will end.

OWNERSHIP – You, as the owner of the contract, may exercise all the rights and options that the contract provides, while this policy is in effect. If you are not the insured and you die before the insured, your estate will become the owner, unless you have named a contingent owner.

You may name a new owner or contingent owner at any time, while this policy is in effect, by submitting a change in ownership request to us. Unless otherwise specified by you, the change in ownership will be effective as of the date you signed that request, whether or not you or the insured is alive when we receive it. Each change in ownership will be subject to payments made or other actions taken by us before the request for that change was received by us.

ASSIGNMENT – You may assign the contract by submitting notice of the assignment to us. Unless otherwise specified by you, the assignment will be effective as of the date the notice of assignment is signed by you and is subject to payments made or other actions taken by us before the assignment was received by us. We are not responsible for the validity or the effect of an assignment.

MISREPRESENTATION & CONTESTABILITY – We may contest the validity of the contract, treat it as void and refuse to pay a benefit if a statement or answer on the application misrepresents or fails to disclose a fact material to the insurance. Except for fraud, we will not contest the contract after it has been in effect during the lifetime of the insured for two years from the policy date. Fraud includes, but is not limited to, a material misrepresentation of the smoking habits of the insured.

In addition, if we allow you to reinstate this policy or make a change or addition to it, based on evidence of insurability, then we can contest the reinstatement, change or addition if there is a material misrepresentation or omission in the application for that reinstatement, change or addition. Except for fraud, we will not contest after a change, addition or the reinstated insurance has been in effect during the lifetime of the insured for two years from the effective date of that change, addition or reinstatement, as shown in our records.

MISSTATEMENT OF AGE OR SEX – If the date of birth or sex of the insured has been misstated, the benefit amount and each rider benefit amount, if any, shall be increased or decreased, at any time, to the amount, as determined by us, that would have been provided by the premium paid for that coverage, using the correct age and sex. However, where age affects the start or termination of coverage correct age will govern. If we would not have issued this policy because the insured's correct age on the policy date did not meet our then current age requirements, we will declare this policy void and return all premiums paid, without interest, to you.

PREMIUMS – The first total premium is due on the policy date. Future premium due dates are determined by the frequency of payment selected in the application, unless changed as shown in our records. Each total premium must be paid on, or before, its due date or within the grace period.

Premium amounts and the period of years for which they are payable are shown in the Benefit and Premium Information Schedule. Subject to our administrative rules in effect at that time, you may change the frequency of payment on any premium due date by submitting a request to change the frequency of payment to us. The premium for a frequency will be based on our frequency factors in effect at the time of change.

CHANGE IN PREMIUMS – The premium amounts shown in the Benefit and Premium Information Schedule are only guaranteed for the first five policy years. We reserve the right to change the premium amounts after that, but not more than once in a 12 month period. We will give you at least 45 days notice of a change to a premium amount. A change in a premium amount will not discriminate based upon changes in the insured's health after the policy date.

GRACE PERIOD – After the first premium is paid as due, we will allow a period of 31 days after the premium due date for payment of each subsequent premium. This is the grace period. If a premium is not paid on or before its due date, that premium is in default. If that premium is still unpaid at the expiration of the grace period, this policy will automatically lapse. If the insured is diagnosed with, or undergoes, a covered condition during the grace period and the claim is approved, we will deduct any unpaid premium from the benefit amount payable. No benefit is payable for a covered condition that is diagnosed, or undergone, while this policy is not in effect.

REINSTATEMENT – This policy may be reinstated within two years of effective date of lapse, as shown in our records. Reinstatement requires: (1) a signed application; (2) evidence which satisfies us of (a) the good health and (b) other aspects of the insurability of the insured; and (3) payment of the unpaid premium plus interest, at a rate determined by us or as prescribed by applicable law.

The unpaid premium will be the sum of:

a) The total premiums due but not paid in full on or before the effective date of lapse; plus
b) The total premiums that would have been due, from the effective date of lapse to the effective date of reinstatement, as shown in our records, if this policy had not lapsed.

Reinstatement is subject to our approval. If we approve reinstatement of this policy, the moratorium period and the two year contestability period will begin anew from the effective date of reinstatement.

CURRENCY – All payments to or by us will be in Canadian dollars.

LIMITATION PERIOD – A person entitled to make a claim under this policy may begin a lawsuit to enforce their claim up to two years after the date that the claim arises, or longer if permitted by applicable law. Currently, the applicable laws with respect to limitation periods are as follows, depending on which province or territory's laws apply to this policy:

Every action or proceeding against an insurer for the recovery of insurance money payable under this policy is absolutely barred unless commenced within the time set out in:

- **The *Insurance Act*** in effect in the relevant province or territory, for policies governed by the laws of Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, Northwest Territories, or Nunavut;
- **The *Limitations Act*** in effect in Saskatchewan or Newfoundland, for policies governed by the laws of those provinces;
- **The *Limitations Act, 2002,*** for policies governed by Ontario law;
- **The *Civil Code,*** for policies governed by Quebec law.

However, please note that laws with respect to limitation periods may change from time to time, so it's important to check the most recent laws when a claim arises.

APPLICABLE LAW – This policy is governed by the laws of the province or territory where the policy was made, which is where you signed the application in the absence of evidence to the contrary. That jurisdiction's conflict of laws rules will not apply.

NON-PARTICIPATING – This policy is non-participating. It does not earn dividends.

NOTIFICATIONS – Notification(s) we send to you about this policy or a rider will be sent to your last address shown in our records. You must notify us of a change in address for you or the insured. If premiums are being paid under a pre-authorized debit plan you must notify us of a change in banking information.

Notifications about this policy or a rider may, with your consent, be sent or provided to you by electronic means, if permitted by our administrative practices.

Notifications and requests that you make to us must, if required by us, be made using our then current form for making such notification or request. Every notification or request that you make to us must be signed by you, if required by us, and received by us for us to act on it. Each will be deemed received by us as of the date shown in our records.

Notifications and requests that you make to us may, if permitted by, and subject to, our administrative practices in effect at that time, be by electronic means.

BENEFIT PROVISIONS

BENEFIT – Subject to the terms and conditions of the contract, we will pay the benefit amount to you upon our receipt of evidence, satisfactory to us, that the insured has:

a) Been diagnosed with, or undergone, a covered condition, while this policy is in effect; and
b) Survived to the end of the survival period.

The benefit amount payable, if any, will be paid as a lump sum.

Payment of a second benefit amount is possible under this policy, however only one benefit amount will be paid under each category of covered conditions regardless of how many covered conditions the insured is diagnosed with or undergoes.

As of the date of the first payment of a benefit amount under a covered conditions category, coverage under that same category ends. Premiums payable thereafter will be adjusted based upon the category of covered conditions for which coverage remains in effect.

After the second payment of the benefit amount this policy will end.

MAKING A CLAIM – Written notice of claim, for a benefit payment under this policy, must be received by us for us to act upon it. The notice should contain enough information to identify the insured. After we receive notice of claim, we will send you the forms that are to be used to file a claim under this policy.

We must receive written proof, satisfactory to us, that the insured has been diagnosed with, or undergone, a covered condition, before we will pay the benefit amount payable, if any. That proof must include certification by the applicable specialist of his/her diagnosis of a covered condition or determination that the surgery was medically necessary.

We reserve the right to require proof, satisfactory to us, of the date of birth and sex of the insured before paying a claim.

CLAIMS FOR COVERED CONDITION OCCURING OUTSIDE OF CANADA OR THE UNITED STATES – If a covered condition is diagnosed or undergone while the insured is outside of Canada or the United States, then no benefit amount will be paid unless, in addition to the requirements for a claim for a covered condition occurring in Canada or the United States:

a) We are provided with the insured's medical records that we request;
b) Those medical records provide confirmation, satisfactory to us, that the same diagnosis would have been made, or the same surgery would have been advised, if the insured had been in Canada or the United States; and
c) If required by us the insured undergoes a medical examination by a physician we appoint.

COVERED CONDITIONS – Coverage is provided under this policy for the conditions, disorders, illnesses and surgeries described below:

Category 1 – Cancer Plus

1. Aplastic Anemia

A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist.

2. Benign Brain Tumour

A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits. These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The diagnosis of benign brain tumour must be made by a specialist.

For purposes of this policy, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this covered condition for:

- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

Moratorium Period Exclusion – We will not pay the benefit amount under this covered condition if, during the moratorium period, the insured has any of the following:

- A sign, symptom or investigation leading, directly or indirectly, to a diagnosis of benign brain tumour (covered or not covered under this policy), regardless of when the diagnosis is made; or
- A diagnosis of benign brain tumour (covered or not covered under this policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not reported to us within this six month period we have the right to deny any claim for benign brain tumour, or any critical illness caused by any benign brain tumour or its treatment.

3. Life-Threatening Cancer

A definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of life-threatening cancer must be made by a specialist and must be confirmed by a pathology report.

For purposes of this policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
    - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF; or
    - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF.
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions – We will not pay the benefit amount under this covered condition for:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;
- Malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than medication to counteract the effects from hormonal oversecretion by the tumour; or
- Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

Moratorium Period Exclusion – We will not pay the benefit amount under this covered condition if, during the moratorium period, the insured has any of the following:

- A sign, symptom or investigation leading, directly or indirectly, to a diagnosis of cancer (covered or not covered under this policy), regardless of when the diagnosis is made; or
- A diagnosis of cancer (covered or not covered under this policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not reported to us within this six month period we have the right to deny any claim for life-threatening cancer, or any critical illness caused by any cancer or its treatment.

Category 2 - Cardiac Plus

1. Aortic Surgery

The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist.

Exclusions – We will not pay the benefit amount under this covered condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

2. Coronary Artery Bypass Surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a specialist.

Exclusions – We will not pay the benefit amount under this covered condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

3. Heart Attack (Acute Myocardial Infarction)

A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- Heart attack symptoms;
- New electrocardiogram (ECG) changes consistent with a heart attack; or
- Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

The diagnosis of heart attack (acute myocardial infarction) must be made by a specialist.

Exclusions – We will not pay the benefit amount under this covered condition for:

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

4. Heart Valve Replacement or Repair

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

The surgery must be determined to be medically necessary by a specialist.

Exclusions – We will not pay the benefit amount under this covered condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

5. Stroke (Cerebrovascular Accident Resulting in Persistent Neurological Deficits)

A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, hemorrhage, or embolism, with:

a) Acute onset of new neurological symptoms, and
b) New objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of stroke (cerebrovascular accident resulting in persistent neurological deficits) must be made by a specialist.

For purposes of the policy, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision , measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions – We will not pay the benefit amount under this covered condition for:

- Transient Ischemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischemic disorders of the vestibular system;
- Death of tissue of the optic nerve or retina without total loss of vision of that eye; or
- Lacunar infarcts which do not meet the definition of stroke as described above.

STATUTORY CONDITIONS

If this policy's applicable law jurisdiction is other than Quebec, then, as required by provincial and territorial laws, the following statutory conditions apply unless otherwise indicated. If this policy's applicable law jurisdiction is Quebec, then you and we agree to be bound by these conditions.

THE CONTRACT – The application, this policy, any document attached to this policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

WAIVER *(Not applicable if this policy's applicable law jurisdiction is Alberta, British Columbia, Manitoba, Ontario or Saskatchewan)* - The insurer shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the insurer.

COPY OF APPLICATION – The insurer shall, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

MATERIAL FACTS – No statement made by the insured at the time of application for the contract shall be used in defence of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

NOTICE AND PROOF OF CLAIM – The owner, the insured or the agent of either of them, shall:

a) Not later than 30 days from the date a claim arises under the contract, give written notice of claim to the insurer,
    i. by delivery of the notice, or by sending it by registered mail to the head office or chief agency of the insurer in the province or territory, or
    ii. by delivery of the notice to an authorized agent of the insurer in the province or territory;
b) Within 90 days from the date a claim arises under the contract, furnish to the insurer such proof, as is reasonably possible in the circumstances, of,
    i. the happening of the covered condition,
    ii. the right of the claimant to receive payment, and
    iii. the claimant's age; and
c) If so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the covered condition for which claim is made under the contract.

FAILURE TO GIVE NOTICE OR PROOF- Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year, or in Saskatchewan not later than the limitation period set out in *The Limitations Act*, from the date a claim arises under the contract, and it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

INSURER TO FURNISH FORMS FOR PROOF OF CLAIM – The insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the covered condition giving rise to the claim.

RIGHTS OF EXAMINATION – As a condition precedent to recovery of insurance money under this contract,

a) the claimant must give the insurer an opportunity to examine the person of the insured when and so often as it reasonably requires while the claim is pending; and
b) in the case of death of the insured, the insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies; and
c) in Saskatchewan, the insurer shall bear the costs of any examination or autopsy and shall provide copies of reports of any examination or autopsy to the insured or the insured's representative.

WHEN MONEY PAYABLE OTHER THAN FOR LOSS OF TIME – All money payable under the contract, other than benefits for loss of time, shall be paid by the insurer within 60 days after it has received proof of claim.

LIMITATIONS OF ACTIONS *(Not applicable if this policy's applicable law jurisdiction is Alberta, British Columbia, Manitoba, Ontario, Quebec or Saskatchewan)* - An action or proceeding against the insurer for the recovery of a claim under the contract shall not be commenced more than two years after the date the insurance money became payable or would have become payable if it had been a valid claim.

RETURN OF PREMIUM ON DEATH RIDER

DEFINITIONS – The following terms have the specific meaning shown when used in this rider:

"**Benefit Amount**" means the sum of the eligible premiums paid, without interest.

"Eligible premiums" means the premium for the policy and the premium for this rider. The premium for other riders, if any, attached to the policy are not eligible premiums.

"Insured" means the person who is insured under the policy, as shown in the Benefit and Premium Information Schedule of the policy.

"Policy" means the policy that this rider is attached to, as shown in our records. This rider, while in effect, forms part of the contract. Unless amended by this rider, policy provisions and policy definitions apply to this rider.

WHEN THIS RIDER IS IN EFFECT – This rider takes effect on the same date that the policy takes effect. Once in effect, this rider will remain in effect until the earliest of the following dates:

a) The effective date, as shown in our records, of your request to cancel this rider;
b) The date that a benefit is paid under the policy; or
c) The date the policy is no longer in effect, as described in the policy.

This rider will not be in effect after the earliest of the above dates which means our liability under it will end.

PREMIUMS – Premium amounts for this rider and the period of years for which they are payable are shown in the Benefit and Premium Information Schedule of the policy. While this rider is in effect, the premium for this rider is included in the total premium for the policy. Subject to the When this Rider is in Effect provision, to keep this rider in effect, you need to pay the total premium when due, as described in the policy.

CHANGE IN PREMIUMS – The premium amounts for this rider shown in the Benefit and Premium Information Schedule of the policy are only guaranteed for the first five policy years. We reserve the right to change the premium amounts for this rider after that, but only if the premium for the policy changes, as described in the Change in Premiums provision of the policy.

BENEFIT – Subject to the terms and conditions of the contract, we will pay the benefit amount upon our receipt of proof, satisfactory to us, of the insured's death. That death must occur while this rider is in effect. The benefit amount will be paid as described in the Beneficiary provision. We will not pay both a claim under the policy and this rider's benefit amount.

BENEFICIARY – You may designate one, or more than one, primary or contingent beneficiary, for the benefit under this rider. Each initial primary and contingent beneficiary, if any, is named in the application. If no primary beneficiary is designated in the application, then you will be the initial primary beneficiary.

You may name a new beneficiary at any time, while this rider is in effect, by submitting a change of beneficiary request to us. If you have named an irrevocable beneficiary, then to change that beneficiary, or their share of the benefit amount, you will need to provide either the signed consent of that irrevocable beneficiary or, where permitted by law, a court order instead of that beneficiary's consent. Unless otherwise specified by you, a change of beneficiary will be effective as of the date you signed the request, whether or not you or the insured is alive when we receive it. Each change of beneficiary will be subject to payments made or other actions taken by us before the request for that change was received by us.

Each surviving primary beneficiary will be paid their share of the benefit payable by us, if any, under this rider. That share is shown in the application unless changed, as shown in our records. If a primary beneficiary is deceased on the date that a benefit is payable, that beneficiary's share will be split among the surviving primary beneficiaries. That split will be based upon the ratio of the specified percentages for those surviving beneficiaries to the total percentage for those survivors. If no percentages are specified, then the benefit will be split equally among the surviving primary beneficiaries. If no primary beneficiary is alive on the date that a benefit is payable, then each surviving contingent beneficiary, if any, will be paid their share of the benefit payable by us, if any, in the same manner as described above for the primary beneficiary.

If there is no beneficiary living when a benefit is payable who is entitled to receive the proceeds, then you or your estate shall be deemed to be the beneficiary. If the proceeds have been assigned, an adjustment to the benefit payable to the beneficiary may be made upon approval of a claim.

ACCIDENTAL DEATH BENEFIT RIDER

DEFINITIONS – The following terms have the specific meaning shown when used in this rider:

"Accidental Death" means death that occurs directly and independently of all other causes, from bodily injury, caused solely through external, violent and accidental means, that occurs while this rider is in effect. Death must occur within 365 days after such injury and while this rider is in effect.

"Benefit Amount" means the amount shown in the Benefit and Premium Information Schedule of the policy as the accidental death rider benefit amount, unless changed as shown in our records.

"Insured" means the person who is insured under this rider, as shown in the Benefit and Premium Information Schedule of the policy.

"Policy" means the policy that this rider is attached to, as shown in our records. This rider, while in effect, forms part of the contract. Unless amended by this rider, policy provisions and policy definitions apply to this rider.

WHEN THIS RIDER IS IN EFFECT – If this rider was attached to the policy on the policy date, then this rider takes effect on the same date that the policy takes effect. If this rider was added to the policy after the policy date, then this rider takes effect on the date, as shown in our records, that we approve the addition of this rider to the policy, as long as the insurability of the insured, for purposes of this rider, has not changed between the date the application for this rider was signed by the insured and the date of that approval.

Once in effect, this rider will remain in effect until the earliest of the following dates:

a) The policy anniversary on which the insured is age 70;
b) The effective date, as shown in our records, of your request to cancel this rider; or
c) The date the policy is no longer in effect, as described in the policy.

This rider will not be in effect after the earliest of the above dates which means our liability under it will end.

PREMIUMS – Premium amounts for this rider and the period of years for which they are payable are shown in the Benefit and Premium Information Schedule of the policy. While this rider is in effect, the premium for this rider is included in the total premium for the policy. Subject to the When this Rider is in Effect provision, to keep this rider in effect, you need to pay the total premium when due, as described in the policy.

BENEFIT – Subject to the terms and conditions of the contract, we will pay the benefit amount upon our receipt of proof, satisfactory to us, that the insured's death was an accidental death. The benefit amount will be paid as described in the Beneficiary provision. Prior to making a payment under this rider, we shall have the right and opportunity to effect an examination of the body and to have an autopsy performed at our expense.

BENEFICIARY – You may designate one, or more than one, primary or contingent beneficiary, for the benefit under this rider. Each initial primary and contingent beneficiary, if any, is named in the application. If no primary beneficiary is designated in the application, then you will be the initial primary beneficiary.

You may name a new beneficiary at any time, while this rider is in effect, by submitting a change of beneficiary request to us. If you have named an irrevocable beneficiary, then to change that beneficiary, or their share of the benefit amount, you will need to provide either the signed consent of that irrevocable beneficiary or, where permitted by law, a court order instead of that beneficiary's consent. Unless otherwise specified by you, a change of beneficiary will be effective as of the date you signed the request, whether or not you or the insured is alive when we receive it. Each change of beneficiary will be subject to payments made or other actions taken by us before the request for that change was received by us.

Each surviving primary beneficiary will be paid their share of the benefit payable by us, if any, under this rider. That share is shown in the application unless changed, as shown in our records. If a primary beneficiary is deceased on the date that a benefit is payable, that beneficiary's share will be split among the surviving primary beneficiaries. That split will be based upon the ratio of the specified percentages for those surviving beneficiaries to the total percentage for those survivors. If no percentages are specified, then the benefit will be split equally among the surviving primary beneficiaries. If no primary beneficiary is alive on the date that a benefit is payable, then each surviving contingent beneficiary, if any, will be paid their share of the benefit payable by us, if any, in the same manner as described above for the primary beneficiary.

If there is no beneficiary living when a benefit is payable who is entitled to receive the proceeds, then you or your estate shall be deemed to be the beneficiary. If the proceeds have been assigned, an adjustment to the benefit payable to the beneficiary may be made upon approval of a claim.

EXCEPTIONS – We will not pay the benefit amount if the insured's death results directly or indirectly from any of the following:

1) Suicide, attempted suicide or intentionally self-inflicted injury, regardless of the insured's state of mind and whether or not the insured was able to understand the nature and consequences of their actions.
2) Committing or attempting to commit an assault or a criminal offence, regardless of whether or not the insured is charged with that criminal offence.
3) War or act of war, whether declared or undeclared.
4) Service, as a combatant or non-combatant, in the military, naval or air force of any country or international authority.
5) Participating in a riot, civil commotion or insurrection or any act incidental thereto.
6) Participating in motorized racing or a speed contest.
7) Travel in an aircraft of any kind, other than as a fare-paying passenger on a fully licensed passenger carrying aircraft on a regularly scheduled flight. Travel in an aircraft includes descent from an aircraft in flight.
8) Bodily or mental infirmity or illness or disease of any kind.
9) The intentional administration of a drug, hypnotic or narcotic, unless administered on the advice of, and at the frequency and dosage prescribed by a, physician or, in the case of a legal, non-prescribed drug, as recommended by the drug manufacturer.
10) Infection, other than an infection occurring simultaneously with and in consequence of an accidental cut or wound.
11) Poisoning or the inhalation of gas or fumes, whether voluntary or involuntary.
12) Injury of which there is no visible contusion or wound on the exterior of the body, except in the case of drowning or internal injury revealed by autopsy.
13) An event related to the operation of a motorized vehicle while the insured is intoxicated by illegal or un-prescribed drugs.
14) An event related to the operation of a motorized vehicle while the blood of the insured contains alcohol and/or tetrahydrocannabinol (THC) in excess of the legal limit for operating a motor vehicle in the jurisdiction where that event occurred.

This page, which follows the policy and rider(s), if any, forms part of the contract.

FORESTERS LIFE INSURANCE COMPANY

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