Foresters Financial

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Application for Conversion

Existing Coverage Information

Certificate/Policy Number: _____ Owner's Name: _____
First Middle Last

Indicate each coverage that is being converted.	Amount being converted.
O Base Term Certificate/Policy	$ _____ O Full Conversion O Partial Conversion
O Term Rider	$ _____ O Full Conversion O Partial Conversion
O Child Term Rider	$ _____ *(Up to 5 times the rider benefit amount.)*

If a partial conversion, indicate what is to happen to remaining coverage? O Maintain Remaining Coverage O Cancel Remaining Coverage

New Coverage Information

Requesting Conversion to (Specify Product Name): _____

Premium Payment Period: O Pay to Age 100 O 20 Pay *(Not available on Express Elite)*

With the following riders included: _____
(Only riders offered by Foresters for conversion and in effect on an existing term certificate/policy may be included in the conversion request.)

If a Child Term Rider conversion, complete the following:

- Within the last 12 months, has the Insured Converting used, by any means, a substance or product containing tobacco or nicotine (excluding cigars) or smoked (including electronic vaporizer or "vaping") marijuana more than four times per week? O Yes O No
- Original document shown to verify the identity of the Insured Converting under the Child Term Rider:

  O Driver's License or O Other Government Issued Photo ID (Indicate Type): _____

  Document Number: _____ Province/Territory of Issue: _____ Expiry Date (MM/DD/YY): _____

Insured Converting

Name: _____ Sex at birth: O Male O Female
First Middle Last

Address: _____
Street Name & Number Apartment Number City/Town Province/Territory Postal Code

Date of Birth (MM/DD/YY): _____ Social Insurance Number: _____
(Not required if converting to Express Elite T100)

Telephone Primary: _____ Email: _____

Work/Other: _____

Owner of New Coverage

Owner is: O Insured Converting O Other *(Complete this section)*

Full legal name of Individual (First, Middle, Last) or Corporation/Entity: _____

Relationship to the Insured Converting: _____

Address: _____
Street Name & Number Apartment Number City/Town Province/Territory Postal Code

Telephone Primary: _____ Email: _____

Work/Other: _____

If an Individual: Date of Birth (MM/DD/YY): _____ Social Insurance Number: _____
(Not required if converting to Express Elite T100)

O Driver's Licence o r O Other Government Issued Photo ID (Indicate Type): _____

Document Number: _____ Province/Territory of Issue: _____ Expiry Date (MM/DD/YY): _____

Owner's International Tax Status *(Not required if converting to Express Elite T100)*

You have an obligation to notify us of any change in tax residency status.

Are you a U.S. Resident for tax purposes, or a U.S. citizen, and/or a resident of another country for tax purposes? **O** Yes **O** No

If YES, provide _____ and/or _____ and _____
U.S. Tax Identification Number | Name of Country(ies) | Tax Identification Number(s)

Payor

Payor is: **O** Insured Converting **O** Owner **O** Other *(Complete this section)*

Full legal name of Individual (First, Middle, Last) or Corporation/Entity: _____

Relationship to the Insured Converting: _____

Address: _____
Street Name & Number | Apartment Number | City/Town | Province/Territory | Postal Code

Telephone Primary: _____ Date of Birth (MM/DD/YY): _____

Work/Other: _____

Beneficiary

Total % share must equal 100% for Primary and 100% for Contingent Beneficiaries.

Each beneficiary is revocable unless indicated otherwise. However, in Quebec the designation of a legally married spouse of the Owner is irrevocable unless expressly indicated to be revocable.

Name	Relationship to Insured Converting (or to Owner in Quebec)	Date of Birth (MM/DD/YY)	% Share	Revocable (R) Irrevocable (I)	Primary (P) Contingent (C)
				O R **O** I	**O** P **O** C
				O R **O** I	**O** P **O** C
				O R **O** I	**O** P **O** C

If a beneficiary is a minor, in all provinces except Quebec, a trustee should be named to receive funds on the minor's behalf. In Quebec, the proceeds payable to a minor will be paid to the parent(s) (or legal guardian, if applicable).

Trustee Name: _____ Relationship to Owner: _____

Premium Details

For monthly (PAD) payment method, there is no premium debit for the first month.

For annual payment method, unless the payor authorizes The Independent Order of Foresters or Foresters Life Insurance Company to withdraw the initial premium by credit card, this application must be accompanied by a current dated cheque for the initial premium due, payable to Foresters. Annualized premium is less for annual payment method.

Premium payment frequency: O Annually O Monthly (PAD) | Premium for the frequency: $_____

Premium payment method:
O Cheque *(Payable to Foresters; annual payment only.)*
O Pre-Authorized Debit (PAD) *(Monthly payment only; complete PAD Plan Agreement.)*
O Credit Card *(Annual payment only. Canada Protection Plan will contact payors who intend to pay by credit card.)*

Payment method for initial premium for annual payment, if different than payment method indicated above: O Cheque O Credit Card

(Initial premium for payment must be provided with this Application if annual payment method is chosen.)

Third Party Determination

A third party is an individual or entity with or will have an interest in a certificate/policy but is not an Insured or an Owner. Some examples of third parties include: premium payor, power of attorney, executor, and trustee.

Is a third party involved with this application for conversion, or will a third party pay the insurance premiums or have the use of, or access to, the cash value of any certificate or policy converted to? **O** Yes **O** No

If YES, complete a separate Third Party Determination Questionnaire (Form 105815 CAN) for each third party.

Pre-Authorized Debit (PAD) Plan Information

Each premium for coverage applied for in this Application (if not paid with this Application), will be drawn from the account identified on the attached VOID cheque, or account information provided, unless otherwise instructed.

If a Savings account is used, please ensure it is eligible for pre-authorized payments.

Monthly withdrawals under this PAD Plan Agreement are: O Personal Related O Business Related

Withdrawal date requested (1st – 28th): _____

PAD bank account information to be taken from: O Attached VOID cheque O Banking information below *(complete if cheque is not attached)*

Type of account: O Chequing O Savings

Transit # (5 digits): _____ Account #: _____

Financial Institution # (3 digits): _____ Name of Financial Institution: _____

Address of Financial Institution: _____
Street Name & Number City/Town Province/Territory Postal Code

Pre-Authorized Debit (PAD) Plan Agreement

For purposes of this Agreement: "Insurer" means, as applicable, each of The Independent Order of Foresters and Foresters Life Insurance Company; "Certificate" means a certificate or policy issued by an Insurer and includes each rider that is attached to it.

The payor, by signing below, verifies that the payor is an account holder of the account identified above or on the attached VOID cheque and agrees that:

1. The Insurer issuing a Certificate is authorized to make deductions monthly under this Agreement from that account or another account later identified or substituted by the payor for premiums and/or other payments for each Certificate issued by that Insurer in response to this Application, such as for additional coverage or loan repayment(s);
2. The financial institution from which the deductions are to be made is authorized to treat each deduction by the Insurer as though the payor made it personally;
3. The Insurer reserves the right to determine when the first deduction, if any, will be made and the amount of that deduction for each Certificate issued by it and the subsequent deduction amounts may be variable;
4. This Agreement is effective immediately and will continue until terminated, which either the payor or the Insurer may do at any time by providing notice of at least 30 days to the other. Payor may obtain a sample cancellation form or further information on the right to cancel a PAD Plan Agreement at his/her financial institution or by visiting www.payments.ca;
5. Should funds not be available due to insufficient funds, the Insurer may, at its option do further resubmits and/or draw from the payor's account on the next scheduled withdrawal date for the insufficient amount applicable to each Certificate, while that Certificate is in effect;
6. The payor has certain recourse rights if any debit does not comply with this Agreement. For example, the payor has the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on recourse rights, the payor may contact his or her financial institution or visit www.payments.ca; and
7. The payor may contact the Insurer at its address and phone number:
   Attention: Certificate Owner Services, Foresters, 789 Don Mills Road, Toronto, ON M3C 1T9, 800-828-1540

The payor waives the right to receive pre-notification of: (i) the amount and date of the first deduction and any subsequent deductions; (ii) a change in the deduction amount for each Certificate in effect; and (iii) a change in amount requested by the payor by whatever means.

For electronic PAD agreements only: The payor and payee agree to reduce the period for providing the written confirmation of the PAD Agreement to three (3) calendar days before the first deduction.

The payor authorizes disclosure of payor and account information for identity verification and record keeping purposes and to administer payments, the Certificate, and benefits. The bank account holder must sign this PAD Plan Agreement as his/her name appears on bank records for the account provided.

Signature of Account Holder: **X** _____ Date (MM/DD/YY): _____

Signature of Joint Account Holder (if applicable): **X** _____ Date (MM/DD/YY): _____

Agreements

For purposes of this Agreement: "Insurer" means, as applicable, each of The Independent Order of Foresters and Foresters Life Insurance Company; "Certificate" means a certificate or policy issued by an Insurer and includes each rider that is attached to it. "Application" means this Application for Conversion and includes additional forms, if any, that are part of this Application. "I/Me" means individually each person identified in this Application as either the insured converting or an owner, and the parent/legal guardian signing this Application if the insured converting is a minor (under age 16 or age18 in Quebec).

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

I understand and agree that: 1) The conversion requested in this Application will be processed subject to the terms of the certificate or rider being converted and the Insurer's current administrative rules. 2) The certificate issued, as a result of this Application, comes into effect as described in, and subject to, the terms of that insurance certificate. There is no conditional or temporary coverage in effect even if an amount was provided, authorized, or collected, as premium. 3) The Insurer has the right to contest the certificate, issued as a result of this Application, based on the evidence of insurability submitted for the purposes of converting a certificate or rider or a reinstatement. This means that the certificate, issued as a result of this Application, may be voided if a material misrepresentation was made with respect to a certificate or rider being converted. For the coverage converted, the time limits for contestability and suicide will run from the date the certificate or rider being converted was issued or last reinstated, whichever is later. 4) Coverage, if any, for the insured under the certificate or rider being converted will terminate or be reduced, as described in that certificate or rider. 5) No advisor, medical examiner or any other person, except for the Insurer's President or Corporate Secretary, or successor positions, has power on behalf of Foresters to make, modify, or discharge a certificate. 6) The Insurer may contact or send messages to me, including pre-recorded and text messages and calls or messages by use of an automatic telephone dialing system, using the phone number(s), including wireless number(s), either provided in this Application or number(s) that I later provide. 7) If I have chosen to provide a current internet email address or other electronic contact information in this Application or choose to provide such address or contact information in the future, the Insurer, its parents, subsidiaries and affiliates may use that address or contact information to send messages, information or documents to me electronically relating, directly or indirectly, to this Application and the certificate, or to membership, events, benefits, claims, administration or other goods and services.

I expressly agree to have this Application, the certificate and any related documents in English. Je demande expressément que ce document ainsi que tous les documents y afférents soient rédigés en anglais.

☐ By checking this box, I consent to receiving written or electronic messages from or on behalf of an Insurer with information about other products and services that may be of interest to me. I may withdraw my consent at any time.

X _____

Signature of insured converting (If the insured converting is not a minor.)	Signed in (Province/Territory)	Date (MM/DD/YY)

X _____

Signature of owner of the policy/certificate being converted from (If other than insured converting.)	Signed in (Province/Territory)	Date (MM/DD/YY)

X _____

Signature of owner of new certificate (If other than insured converting or owner of the certificate/policy being converted from.)	Signed in (Province/Territory)	Date (MM/DD/YY)

Parent /Legal guardian's full legal name: _____ Signature of parent/legal guardian: **X** _____
(If the insured converting is a minor and an owner is not a parent/guardian.)

Advisor Certification

I, the Advisor, by signing below certify that: 1) I provided to the owner of the new certificate a statement of disclosure outlining the companies I represent, the fact that I receive compensation for the sale of life and health insurance company products, and that I may receive additional compensation in the form of bonuses, conference programs or other incentives. I have also disclosed any conflicts or potential conflicts of interest with respect to this transaction. 2) To the best of my knowledge and belief, the information provided in this Application is current, correct and complete. I am not aware of any additional information that is material to the acceptance of this Application that has not been disclosed in this Application. 3) I have verified the identity of the owner of the new certificate. I confirm that the identification details provided in this Application match the original identification documents shown to me, and that reasonable effort was exercised to determine if the owner of the new certificate is acting on behalf of a third party. If I suspect that an undisclosed third party is involved, I will immediately email details to compliance@foresters.com.

Advisor's Name (print full name): **X**_____ Advisor Code: _____

Advisor's signature: **X**_____ Date (MM/DD/YY): _____

XXXXXX CAN (YY/YY)