Canada Protection Plan™
Application for Life Insurance

Distributed by

A Foresters Financial™ Company

CANADA PROTECTION PLAN®
Simply Peace of Mind
A Foresters Financial™ Company

COVID-19 (Coronavirus) Exposure Questionnaire

To be completed when the proposed insured is age 50 or over AND applying for Simplified Elite, Preferred or Express Elite plans.

Insured's Name :

Instructions to Submit:

E-Access • You may attach a copy of this form when submitting the application via E-Access.

OR Email • If submitting separately from the application please email this form to newbusiness@cpp.ca

If the form is signed with a digital signature and not a wet signature, please include a copy of the client's government issued Photo ID with wet signature displayed (i.e. Passport, Driver's Licence, etc.) for verification purposes.

1 | Have you experienced any of the following signs or symptoms within the last 14 days? ○ Yes ○ No

If YES - Check all that apply and additional details.

- ☐ Fever
- ☐ Persistent cough that has not subsided
- ☐ Shortness of breath
- ☐ Flu-like fatigue
- ☐ Sore throat
- ☐ Nausea, vomiting and/or diarrhea
- ☐ Loss of smell or taste

2 | Have you been advised to be tested for Coronavirus (COVID-19), or are you or have you been in close contact with anyone who has been quarantined for or diagnosed with Coronavirus (COVID-19)? ○ Yes ○ No

If YES - Please provide details including test result and date of exposure.

____

3 | In the past 21 days have you returned from travel abroad? ○ Yes ○ No

If YES - Please advise date of return to Canada.

____

Express Elite Only

4 | Are you currently in good health, in relation to COVID-19? ○ Yes ○ No

If NO - Please provide details.

Declaration

I confirm that the answers I have given are true and is a complete disclosure of all information requested in this questionnaire.

I agree that this form will constitute part of my application for insurance and will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters Life Insurance Company and that any misrepresentation or failure to disclose any material fact by me may invalidate my insurance.

Signed at ____________________ **on** ________ **of** ______________ , ________ ______________________________
City, Province Day Month Year **Proposed Insured Signature**

CANADA PROTECTION PLAN and the logo are trademarks of Canada Protection Plan Inc., a Foresters Financial Company,
No Medical and Simplified Issue Life and Critical Illness Insurance Underwritten by Foresters Life Insurance Company.

Application Checklist

To ensure priority service:

1 | Ensure that all applicable questions are completed before submitting. Print legibly in dark ink. Do not use "ditto" marks. Do not draw a line through any questions or answers. Do not make erasures or use liquid paper. If you cross out an error, each person signing the application must initial it.

2 | Attach an illustration for each policy applied for.

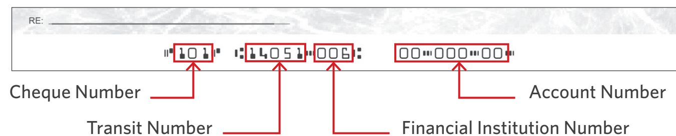
3 | Submit applicable disclosure forms if replacing existing life insurance.

4 | Note that the initial premium will be applied on the policy date, which will be the date the policy is actually issued.

5 | If premium payment is annual, ensure that the initial premium is paid with the application. COD applications are NOT allowed.

- If the initial premium is to be paid by cheque, include a current dated cheque payable to Foresters Life Insurance Company with the same date as the application.
- If the initial premium is to be paid by credit card, the frequency of premium payments must be annual.

6 | If premium payment is monthly by Pre-Authorized Debit (PAD), include a void cheque or complete the banking information on page 6 (see sample cheque below). For monthly (PAD) payment method, there is no premium debit for the first month.



7 | Each Advisor MUST have a valid licence and E&O on file with Canada Protection Plan or copies must be attached to this application.

8 | Notify your client that they may receive a verification call from the Insurer to verify the information on their application.

Plan Availability

[1] Maximums shown are for combined coverage under all Life and Term policies of same Plan category.

[2] Minimum is $50,000 for a Preferred term plan or rider or a Preferred Elite term rider, and $500,000 for a Preferred Elite term plan.

Base Plan	Issue Ages	Minimum	Maximum
Guaranteed Acceptance Life	18 — 60	$10,000	$50,000
	61 — 75	$5,000	$50,000
Deferred Life	18 — 60	$10,000	$75,000
	61 — 80	$5,000	$50,000
Deferred Elite Life	18 — 60	$10,000	$350,000 [1]
	61 — 80	$5,000	$350,000 [1]
Simplified Elite Life	18 — 60	$10,000	$500,000 [1]
	61 — 80	$5,000	$350,000 [1]
Preferred Life	18 — 80	$50,000	$1,000,000 [1]
Preferred Elite Life	18 — 80	$500,000	$1,000,000 [1]
Base Plan or Rider (available as Deferred Elite, Simplified Elite, Preferred and Preferred Elite)			
10 Year Term	18 — 70	$25,000 [2]	Maximum depends on age and plan — see above
20 Year Term	18 — 60	$25,000 [2]	
25 Year Term	18 — 55	$25,000 [2]	
25 Year Decreasing Term	18 — 60	$25,000 [2]	
Rider Only			
Accidental Death Benefit	18 — 65	Lesser of one times coverage and $10,000	Lesser of five times coverage and $250,000
Child Term Benefit	18 — 60 (parent)	$5,000, $10,000 or $15,000	
Hospital Cash Benefit	18 — 65	$25/day, $50/day or $100/day	

INSURED

In this application, Insured means the person proposed to be the insured.

1 Must be a Canadian Citizen, Permanent Resident or with a valid work or study permit to apply.

The maximum amount for an Insured on a work or study permit is $250,000.

2 For permanent life insurance, when the Insured is the Owner, if SIN is not provided here, we may ask for it in future, including on surrender of the policy.

3 Physician's information is required for all products other than Guaranteed Acceptance Life.

Name .... First / Middle / Last

○ Male ○ Female

Date of Birth .... MM / DD / YY

Country of Birth ....

○ Canadian Citizen [1]
○ Permanent Resident [1]
○ Work Permit/Study Permit [1]

Telephone
Primary ....
Work / Other ....

Address .... Street Name & Number / Apartment Number

.... City / Town / Province / Territory / Postal Code

Best date and time to call for verification, if applicable (be specific):
.... Date / Time

Social Insurance Number [2] ....

Email (Optional) ....

Occupation ....

Driver's Licence (or Gov't Issued Photo ID # and Type)
.... Number (and type) / Province / Territory of Issue / Expiry Date (MM/DD/YY)

Are you a Foresters member?
○ Yes ○ No, applying for membership

Your physician's name [3] ....

Your physician's address [3] ....

OWNER

Complete Owner details only if different than Insured

4 If the Owner is a corporation, the signature must be accompanied by either the company name and title of the signing officer OR a company seal.

5 For permanent life insurance, if SIN is not provided here, we may ask for it in future, including on surrender of the policy.

Owner is: ○ Insured ○ Other — *complete this section*

Full Legal Name, or Corporation/Entity [4] ....

Address .... Street Name & Number / Apartment Number

.... City / Town / Province / Territory / Postal Code

Telephone .... Primary

.... Work / Other

Relationship to Insured ....

Email (Optional) ....

Driver's Licence (or Gov't Issued Photo ID # and Type)
.... Number (and type) / Province/Territory of Issue / Expiry Date (MM/DD/YY)

Social Insurance Number [5] ....

CONTINGENT OWNER

Full Legal Name, or Corporation/Entity .... Relationship to Owner ....

BENEFICIARY

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

! Important: 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.

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

Trustee Name .... Relationship to Owner ....

In Quebec, the proceeds payable to a minor will be paid to the parent(s) (or legal guardian, if applicable).

PAYOR

Complete Payor details only if different than Insured or Owner.

Payor is: ○ Insured ○ Owner ○ Other — *complete this section*

Relationship to Insured ....

Full Name .... Date of Birth .... MM / DD / YY

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

02 Owner's International Tax Status

Complete only if applying for permanent life insurance.

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

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

03 Eligibility Questions

For all Eligibility Questions, "You" and "Your" refer to the Insured.

Complete these questions for all applications. Then continue to the next section.

1 | Within the past 12 months, have you used by any means, a substance or product containing tobacco or nicotine (excluding cigars), or have you smoked (including electronic vaporizer or "vaping") marijuana more than six times per week? ◯ Yes ◯ No
If YES, smoker rates applicable

2 | Will premiums be stopped, or coverage be reduced or discontinued, on any existing life insurance coverage or annuity if the insurance applied for in this application is issued? ◯ Yes ◯ No
If YES, state insurer, amount and plan, and complete the Comparison Disclosure Statement or Life Insurance Replacement Declaration required in your province.

Insurer ____________ Amount ____________ Plan ____________

A NO MEDICAL REQUIRED

YES — If a question is answered YES in this section, apply for

Guaranteed Acceptance Life
Maximum $50,000

NO — If ALL NO answers are provided, continue to section **B**

1 | Are you currently incapable of independently carrying out two or more of the basic activities of daily living such as getting up, walking, washing, toileting, dressing or feeding? ◯ Yes ◯ No

2 | Are you currently a resident of a long-term care facility, nursing home, nursing facility, or assisted living residence? ◯ Yes ◯ No

3 | Are you in need of an organ transplant, on a waiting list for an organ transplant or the recipient of an organ transplant (excluding corneal transplants)? ◯ Yes ◯ No

4 | Within the past 30 days, have you been admitted to a hospital for more than 48 hours (excluding pregnancy)? ◯ Yes ◯ No

5 | Within the past 60 days, have you been advised by a physician:
a. Of any abnormal diagnostic tests? ◯ Yes ◯ No
b. To have surgery or a diagnostic test or special test of any type? ◯ Yes ◯ No
c. To consult with a physician, medical institution or specialist that has not yet been completed? ◯ Yes ◯ No

6 | Have you ever been diagnosed with a life threatening, critical or terminal condition for which a physician has estimated that you have 24 months or less to live? ◯ Yes ◯ No

7 | Have you ever had, been told you have, or been treated for Acquired Immunodeficiency Syndrome (AIDS) or have you ever tested positive for Immunodeficiency virus (HIV)? ◯ Yes ◯ No

8 | Within the past ten years, have you had, been told you have, been treated for, or been advised to have an investigation, that has not yet been completed, for:
a. Metastatic cancer or more than one occurrence of cancer (excluding basal cell carcinoma)? ◯ Yes ◯ No
b. Cystic Fibrosis or a chronic respiratory condition (excluding sleep apnea) which required the continuing administration of oxygen? ◯ Yes ◯ No
c. Dementia, Alzheimer's, Muscular Dystrophy, Huntington's Chorea or Amyotrophic Lateral Sclerosis (ALS)? ◯ Yes ◯ No
d. Congestive heart failure or cardiomyopathy? ◯ Yes ◯ No

9 | Have you ever had, been treated for, or been diagnosed prior to age 40, with: chronic kidney disease, stroke (CVA), transient ischemic attack (TIA), aneurysm, coronary artery disease, heart bypass surgery, angioplasty, stent insertion, angina or heart attack? ◯ Yes ◯ No

10 | Within the past 12 months, have you used narcotics or barbiturates (except as prescribed by a physician), heroin, psychoactive drugs, cocaine, crack or other similar agents, or been a resident of a drug or alcohol treatment facility? ◯ Yes ◯ No

11 | Within the past 12 months, have you been convicted of, awaiting sentencing for, incarcerated for, or on probation for a criminal offence; or do you currently have any criminal charges pending? ◯ Yes ◯ No

12 | Referring to the Height and Weight table shown, is your weight greater than that indicated for your height? ◯ Yes ◯ No

Height and Weight Table

Height	Weight
4'8" — 4'10" 142 cm — 147 cm	230 lbs 104 kg
4'11" — 5'1" 148 cm — 155 cm	247 lbs 112 kg
5'2" — 5'4" 156 cm — 163 cm	273 lbs 124 kg
5'5" — 5'7" 164 cm — 170 cm	300 lbs 136 kg
5'8" — 5'10" 171 cm — 178 cm	328 lbs 149 kg
5'11" — 6'1" 179 cm — 185 cm	358 lbs 162 kg
6'2" — 6'4" 186 cm — 193 cm	389 lbs 176 kg
6'5" — 6'7" 194 cm — 201 cm	420 lbs 191 kg

B — NO MEDICAL REQUIRED

YES — If a question is answered YES in this section, apply for
Deferred Life
Maximum $75,000

NO — If ALL NO answers are provided, continue to section **C**

1 | Within the past 12 months, have you had, been told you have, or been treated for:

a. Cardiac chest pain (angina), heart attack (myocardial infarction), coronary artery disease, stroke (CVA), heart bypass surgery, angioplasty, stent insertion or more than one transient ischemic attack (TIA)? ○ Yes ○ No

b. Circulatory problems in the legs and/or feet (peripheral arterial or vascular disease)? ○ Yes ○ No

c. Chronic kidney disease, or been investigated or been advised to be investigated for polycystic kidney disease (PKD), or have a family history of PKD and have not been investigated? ○ Yes ○ No

d. Liver disease such as, but not limited to, cirrhosis or hepatitis (excluding Hepatitis A or B)? ○ Yes ○ No

e. Cancer including, but not limited to, leukemia and lymphoma (excluding basal cell carcinoma)? ○ Yes ○ No

2 | Are you under age 30 and have been diagnosed with diabetes (excluding gestational diabetes) or are undergoing investigation for diabetes or your blood sugar levels? ○ Yes ○ No

C — NO MEDICAL REQUIRED

YES — If a question is answered YES in this section, apply for
Deferred Elite Plans
Maximum $350,000

NO — If ALL NO answers are provided, continue to section **D**

Height and Weight Table

Height	Weight
4′8″ — 4′10″ 142 cm — 147 cm	79 — 185 lbs 36 — 84 kg
4′11″ — 5′1″ 148 cm — 155 cm	87 — 199 lbs 39 — 90 kg
5′2″ — 5′4″ 156 cm — 163 cm	94 — 215 lbs 43 — 98 kg
5′5″ — 5′7″ 164 cm — 170 cm	104 — 235 lbs 47 — 107 kg
5′8″ — 5′10″ 171 cm — 178 cm	115 — 260 lbs 52 — 118 kg
5′11″ — 6′1″ 179 cm — 185 cm	125 — 282 lbs 57 — 128 kg
6′2″ — 6′4″ 186 cm — 193 cm	139 — 305 lbs 63 — 138 kg
6′5″ — 6′7″ 194 cm — 201 cm	149 — 333 lbs 68 — 151 kg

1 | Within the past 12 months, have you had, been told you have, or been treated for: bipolar disorder, schizophrenia or psychosis? ○ Yes ○ No

2 | Within the past three years, have you been treated for or received medical advice or counseling for the use of drugs or alcohol? ○ Yes ○ No

3 | Within the past three years, have you used narcotics or barbiturates (except as prescribed by a physician), heroin, psychoactive drugs, cocaine, crack or other similar agents? ○ Yes ○ No

4 | a. **Are you age 54 or under** and within the past **three** years, have you had treatment or surgery for or been diagnosed as having cardiac chest pain (angina), heart attack (myocardial infarction), coronary artery disease, heart bypass surgery, angioplasty, stent insertion, stroke (CVA) or chronic lung disease (excluding asthma)? ○ Yes ○ No

b. **Are you age 55 or over** and within the past **two** years, have you had treatment or surgery for or been diagnosed as having cardiac chest pain (angina), heart attack (myocardial infarction), coronary artery disease, heart bypass surgery, angioplasty, stent insertion, stroke (CVA) or chronic lung disease (excluding asthma)? ○ Yes ○ No

5 | **Are you under age 55** with diabetes that was diagnosed more than 20 years ago and is currently treated with insulin? ○ Yes ○ No

6 | Do you have diabetes that is currently treated with insulin and the prescribed dosage of insulin increased within the past six months? ○ Yes ○ No

7 | Have you ever had, been told you have, or been treated for diabetes and any of the following: coronary artery disease, peripheral vascular disease, tingling and loss of feeling in the extremities (neuropathy), amputation, retinopathy or stroke (CVA)? ○ Yes ○ No

8 | Within the past three years have you had, been told you have, or been treated for:

a. Lung cancer? ○ Yes ○ No

b. Colon cancer? ○ Yes ○ No

c. Breast cancer, cervical cancer or uterine cancer? ○ Yes ○ No

d. Malignant melanoma? ○ Yes ○ No

e. Leukemia (all types), lymphoma or multiple myeloma? ○ Yes ○ No

9 | Do you plan to travel outside North America, the Caribbean (excluding Haiti), the United Kingdom or the European Union countries for more than 12 consecutive weeks in the next 12 months? ○ Yes ○ No

10 | Have you had a weight loss of 10% of body weight or more within the past 12 months other than due to intentional dieting? ○ Yes ○ No

11 | Referring to the Height and Weight table shown, is your weight outside the range indicated for your height?
NOTE: For females, deduct 5 lbs. or 3 kg from the lower range for the given height ○ Yes ○ No

D — NO MEDICAL REQUIRED

YES — If a question is answered YES in this section, apply for
Simplified Elite Plans
Maximum $500,000

NO — If ALL NO answers are provided, continue to section E ONLY if you wish to apply for
Preferred Plans*
Preferred Elite Plans*

* You may qualify for one of these plans subject to underwriting requirements and approvals.

1 | Within the past 12 months, have you been told you have, been treated for, or are you currently under investigation for multiple sclerosis? ○ Yes ○ No

2 | Have you ever had or been treated for cancer including, but not limited to, leukemia and lymphoma (excluding basal cell carcinoma)? ○ Yes ○ No

3 | Within the past six months, have you been told you have or been treated for diabetes? ○ Yes ○ No

4 | Within the past three years, have you been incarcerated or on probation for a criminal offence or are criminal charges now pending excluding a single DUI? ○ Yes ○ No

5 | Within the past two years, have you been involved in the operation of an aircraft as a pilot (scheduled commercial pilots excluded) or involved in any hazardous sports, or do you plan to do so within the next year? ○ Yes ○ No

6 | Within the past two years, has your driver's licence been suspended or revoked, or have you had more than three moving violations within the past 12 months? ○ Yes ○ No

E — MAY BE SUBJECT TO UNDERWRITING

Preferred Plans

Minimum $50,000
Maximum $1,000,000

The plan you may be eligible for will be determined by our underwriting department.

1 | Have you ever been prescribed a medication that was for more than 30 days for a medical condition? ○ Yes ○ No

If YES, please advise the name of the prescription(s) and the nature of the medical condition they were prescribed for.

Details

2 | Date you last consulted a physician ....

Reason for consult ....

F — SUBJECT TO UNDERWRITING

Preferred Elite Plans

Minimum $500,000
Maximum $1,000,000

The plan you may be eligible for will be determined by our underwriting department.

1 | What is your current height and weight? **Imperial** ....ft'in" / ....lbs **Metric** .... cm / .... kg

2 | Have two or more members of your immediate family (father, mother, brothers, sisters) ever had, been treated for, or been diagnosed with cancer, heart disease, stroke (CVA) or transient ischemic attack (TIA) before the age of 60? ○ Yes ○ No

If YES, please provide details including age and cause of death or diagnosis of each.

Details

3 | Within the past 24 months, have you used by any means (including electronic vaporizer or "vaping"), a substance or product containing tobacco, nicotine or marijuana? *If YES, smoker rates applicable.* ○ Yes ○ No

04 Coverage Details

1 Maximum two term insurance riders

- Riders can only be added if base is longer than rider term period (not equal).
- Term insurance riders are not available with Guaranteed Acceptance Life, Deferred Life or any 20 Pay plans.

2 Complete Child Term Benefit questions on page 5

Not available with:
- Guaranteed Acceptance Life
- Deferred Life

3 Not available with:
- Guaranteed Acceptance Life
- Deferred Life
- Deferred Elite Life
- Deferred Elite Term

Permanent Insurance Plan	Premium Payment Period	Amount of Insurance
○ Guaranteed Acceptance Life *(Ages 18–75)* ○ Deferred Life *(Ages 18–80)* ○ Deferred Elite Life *(Ages 18–80)* ○ Simplified Elite Life *(Ages 18–80)* ○ Preferred Life *(Ages 18–80)* ○ Preferred Elite Life *(Ages 18–80)*	○ Pay to Age 100 ○ 20 Pay *Not available for:* » Guaranteed Acceptance Life » Deferred Life	$ ....

Term Insurance Plan	Term Period	Amount of Insurance
○ Deferred Elite Term ○ Simplified Elite Term ○ Preferred Term ○ Preferred Elite Term	○ 10 Year *(Ages 18–70)* ○ 20 Year *(Ages 18–60)* ○ 25 Year *(Ages 18–55)* ○ 25 Year Decreasing *(Ages 18–60)*	$ ....

Optional Riders	Amount
☐ 10 Year Term [1] *(Ages 18–70)*	$ ....
☐ 20 Year Term [1] *(Ages 18–60)*	$ ....
☐ 25 Year Term [1] *(Ages 18–55)*	$ ....
☐ 25 Year Decreasing Term [1] *(Ages 18–60)*	$ ....
☐ Accidental Death Benefit *(Ages 18–65)*	$ ....
☐ Child Term Benefit [2] *(Ages 18–60)*	○ $5,000 ○ $10,000 ○ $15,000
☐ Hospital Cash Benefit [3] *(Ages 18–65)*	○ $25/day ○ $50/day ○ $100/day

05 Child Term Benefit

ELIGIBILITY QUESTIONS

Identify each child of the Insured under 18 years of age.

Child Name	Date of Birth (MM/DD/YY)	Age (Yrs)	Sex
			○ Male ○ Female
			○ Male ○ Female
			○ Male ○ Female
			○ Male ○ Female

1 | Has any child named above ever received medical care, surgical care, or prescribed medications or been investigated for or diagnosed with: cancer, leukemia, aplastic anemia, congenital or hereditary cardiac or neurological disease, bronchopulmonary dysplasia, cystic fibrosis, chronic kidney disease, Werdnig-Hoffmann disease (Infantile Spinal Muscular Atrophy), muscular dystrophy, chronic hepatitis, HIV positive, developmental problems, diabetes or autism? ○ Yes ○ No

2 | Has any child named above ever been referred by a physician for a specialist's consultation, been advised to have treatment or been advised to have a diagnostic test, any of which have not yet been completed? ○ Yes ○ No

If you answered YES to any of the questions for any child named above, please indicate the child's name below. The child named is excluded from the Child Term Benefit.

Child Name .... Child Name .... Child Name ....

06 Premium Details

PAYMENT PLAN

MONTHLY

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

ANNUAL

For annual payment method, unless the payor authorizes Foresters Life Insurance Company (the Insurer) 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 Life Insurance Company. Annualized premium is less for annual payment method.

Premium payment frequency ○ Annual ○ Monthly (PAD)

Premium for the frequency $ ....

Premium payment method
- ○ **Cheque.** *Payable to Foresters Life Insurance Company; annual payment only.*
- ○ **Pre-Authorized Debit (PAD).** *Monthly payment only; complete PAD Plan Agreement on page 6.*
- ○ **Credit Card.** *Annual payment only; complete Credit Card Payment Details below.*

Payment method for initial premium for annual payment, if different than payment method indicated above. ○ Cheque ○ Credit Card
Initial premium for payment must be provided with this Application if annual payment method is chosen.

CREDIT CARD PAYMENT DETAILS *Complete this section ONLY if paying ANNUALLY by credit card.*

Card Type: ○ VISA ○ MASTERCARD

Card Number .... Cardholder name as it appears on the card ....

Expiry Date .... Signature ....

07 Special Requests / Details

Any special requests, including premium and issue instructions, may be added here.

08 Third Party Determination

A third party is an individual or entity with an interest in a policy, but is not the Insured, Owner, Payor or trustee for a minor beneficiary. Examples include power of attorney and executor.

Is a third party involved with this application for insurance, or will a third party have the use of, or access to, the cash value of the policy? ○ Yes ○ No

If YES, complete a separate Third Party Determination form CP011 for each third party.

09 Pre-Authorized Debit (PAD) Plan Agreement

NOTE: 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.

SAVINGS ACCOUNT

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

SAMPLE CHEQUE

See the Application Checklist (on the inside cover page) for a sample cheque that shows location of transit #, financial institution # and account #.

Monthly Withdrawals under this PAD Agreement are: ○ Personal related ○ Business related

Withdrawal date requested (1st – 28th) ....

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

Type of Account ○ Chequing ○ Savings	Transit # *(5 digits)*	Account # ....
Financial Institution # *(3 digits)*	Name of Financial Institution	

Address of Financial Institution ....

Street Address — City/Town — Province/Territory — Postal Code

PAD PLAN AGREEMENT

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 is authorized to make deductions monthly under this Agreement from that account or another account later identified or substituted by the payor for premium and insurance charges for each Policy issued by that Insurer in response to this Application.

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 Policy issued by it; 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, draw from the payor's account on the next scheduled withdrawal date for the insufficient amount applicable to each Policy while that Policy 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.

7 | If the payor is signing this Agreement electronically, the payor agrees that the time period for providing written confirmation of this Agreement, before the first deduction, can be reduced from 15 days to 3 days. If handwriting the signature, written confirmation is not required before the first deduction which can be made at any time.

8 | The payor may contact the Insurer at its address and phone number:

Attention: Policyowner Services, Foresters, 250 Ferrand Drive, Suite 1100, Toronto, ON M3C 3G8
Phone Number: 1-877-629-9090

The payor waives the right to receive pre-notification of the amount and date of the first deduction and of a change in the deduction amount required as premium or charges for each Policy in effect, or a change in amount requested by the payor by whatever means.

The account holder must sign this PAD Plan Agreement as his/her name appears on bank records for the account provided.

Signature of Account Holder .... Date .... MM / DD / YY

Signature of Joint Account Holder *(if applicable)* .... Date .... MM / DD / YY

DEFINITIONS

These definitions apply for purposes of this Agreement and Authorization.

"Application" means this Canada Protection Plan Application for Life Insurance. "Insured" and "Owner" mean each person identified as such in this Application. "I/me" means individually each person identified in this Application as either the Insured or the Owner. "Insurer" means Foresters Life Insurance Company. "Policy" means a policy issued by the Insurer in response to this Application and includes each rider that is attached to it. "Authorized Purpose" means: assessing, servicing or administering insurance coverage, a Policy, claim or the benefits of membership; identity verification, auditing, products and services; any other purpose as required or permitted by law. "Authorized Person" means the Insurer, reinsurer, advisor, insurance agency, managing general agency and market intermediary related to this Application or a Policy and the respective parent, affiliates and authorized representatives of each and those performing services on behalf of one or more of the preceding in relation to an Authorized Purpose, this Application, or a Policy, benefit claim, membership or management of the respective business of each. "Child" means each child identified in the Child Term Benefit section of this Application.

AGREEMENT

I, by signing this Application, agree that:

1 | The statements and answers contained in this Application, and other evidence of insurability signed or provided by me, are true and complete and will be relied upon by the Insurer in deciding whether to issue a Policy.

2 | For the purpose of determining eligibility for insurance, the Insurer may consider risk characteristics other than those mentioned in the questions in this Application.

3 | A Policy issued, if any, by the Insurer will only come into effect according to the terms of that Policy, which may include factors such as the date this Application was approved, the Policy issue date, payment of the first premium, and provided there is no change in insurability, as described in the Policy, prior to the date of delivery of the Policy.

4 | The Insurer may void the Policy in the event of any misrepresentation by me in this Application or in any other documents or answers delivered to the Insurer in connection with this Application.

5 | No advisor, medical examiner or any other person has authority to advise that any untrue or incomplete answer or information is acceptable and has no power, except for Foresters Life Insurance Company's President or Corporate Secretary, or successor positions, to make, modify, or discharge a Policy.

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

7 | The Insured has received a copy of the Important Notices page.

8 | Changes or corrections made to this Application, if any, by the Insurer are ratified by the Owner if the Policy delivered to the Owner is not returned to the Insurer during the cancellation period.

9 | 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 and its parent, 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 Policy, or to membership, events, benefits, claims, administration or other goods and services.

AUTHORIZATION

A photocopy of this authorization shall be as valid as the original.

I, by signing this Application, authorize, on my own behalf and on behalf of each Child, the collection and use of information about us, by an Authorized Person for an Authorized Purpose, from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan, other insurer or institution; public records; or MIB, Inc.

I, by signing this Application, authorize, on my own behalf and on behalf of each Child, an Authorized Person to make a brief report about my and each Child's personal health information to MIB Inc., even if this Application is cancelled or withdrawn. Information may be disclosed: between and among Authorized Persons; to companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law.

Each person providing this authorization may, by written notice to the Insurer, revoke their authorization. Revoking authorization, however, will not affect action(s) begun before receipt of notice or prevent an Authorized Person from using personal information to administer a Policy, report to MIB Inc. if previously authorized to do so, or to inform of or administer the benefits of membership.

OTHER PRODUCTS AND SERVICES

I consent to receiving information by any method from the Insurer, its parent, subsidiaries and affiliates about other products and services. If you do not want to provide your consent for that purpose, check here ☐ or you may at any time withdraw your consent by writing to our Chief Privacy Officer at: Foresters, 789 Don Mills Rd., Toronto, ON M3C 1T9.

SIGNATURES

This Application must be current dated and received at Canada Protection Plan's Head Office within 14 days of signature date.

I understand and agree that my signature below applies to, and is for the purposes of, this entire Application.

Signature of Insured ....

Signature of Owner (only if different) .... Signature of witness to all signatures ....

Dated at .... (Province/Territory) this .... day of ...., 20 .... Advisor's Name ....

Advisor's Report

ADVISOR INFORMATION

Advisor Name *(first, middle, last)*	Advisor Code	Agency Code	Split %

RELATIONSHIP TO INSURED AND DISCLOSURE

When shown original identification documents to verify identity, you must confirm that the documents are valid, original and unaltered by reviewing both sides of each document.

1 | How long have you known the Insured? ....

2 | Are you related to the Insured? ◯ Yes ◯ No *If YES, what is the nature of your relationship?* ....

3 | Who initiated this application? ◯ Owner ◯ Insured ◯ Advisor ◯ Other *(specify)* ....

4 | Did you meet with the Owner and Insured in person to complete this application? ◯ Yes ◯ No

If NO, please indicate method for obtaining the answer to the questions in this application: ◯ Telephone and/or mail ◯ Video conference / Skype

5 | Did you verify the identity of the Owner, by confirming that the identification details provided in this application match original identification documents shown to you? .... ◯ Yes ◯ No

6 | Was a needs analysis done? .... ◯ Yes ◯ No

7 | Do you know of any information not disclosed in this application that may be important to assessing the insured's eligibility for the plan applied for? .... ◯ Yes ◯ No

If YES, please provide details: ....

REQUIREMENTS ORDERED

Preferred Plans and Preferred Elite Plans ONLY

☐ Blood Chemistry Profile

☐ Paramedical Exam

Name of paramedical provider .... Order Number ....

SIGNATURE OF ADVISOR WHO COMPLETED THIS APPLICATION AND ADVISOR'S REPORT

I provided to the Insured and the Owner the Important Notices page and 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.

To the best of my knowledge and belief, the information provided in the application is current, correct and complete. I am not aware of any additional information that is material to the underwriting and acceptance of this application that has not been disclosed in this application or Advisor's report.

Reasonable effort was exercised by me to determine if the Owner 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@cpp.ca.

Signature of Advisor .... Date .... MM / DD / YY

Signature of training supervisor where required .... Date .... MM / DD / YY

I have reviewed this application and Advisor's report.

Signature of servicing agent if different from above .... Date .... MM / DD / YY

Important Notices

(Detach and present to Insured)

Respecting your privacy is important to us at Canada Protection Plan and Foresters Life Insurance Company. We will maintain your Personal Information in a confidential file to be used at our offices to provide you with our products and services and information about your Foresters membership. Information in your file will be collected, used and disclosed, on a continuing basis, by Canada Protection Plan and Foresters, our employees, reinsurers, agents and representatives, service providers or professional consultants to determine your eligibility for our products and services; to assess or administer claims; to administer your policy and address your questions; to tell you about, and provide, the benefits of membership; provide you with information about products, services or member benefits that may meet your needs; to help us continually improve our services and develop programs for our members; and as further described in the Authorization section of the application. We will restrict access to your file to our employees, service providers, representatives, affiliates and reinsurers who need the information in the performance of their duties for us and to any person or organization to whom you gave consent. Our employees, service providers, representatives, reinsurers and any of their service providers may be located outside Canada. As such, your Personal Information may be subject to the laws of other jurisdictions and may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in those countries. You are entitled to access your Personal Information contained in your file and, when applicable, to have it corrected. You may also ask us not to send you information about our products, services, or member benefits. To do either of these, please write to: Canada Protection Plan at 250 Ferrand Drive, Suite 1100, Toronto, Ontario M3C 3G8. To access our most recent privacy policies, please visit our websites at cpp.ca and foresters.com.

NOTICE REGARDING MIB

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however, make a brief report on it to MIB Inc., formerly known as 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 MIB member company for life, disability or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with the information about you in its file. If you question the accuracy of the information about you in the MIB file, you may contact MIB and seek a correction. The address of MIB's information office is: MIB, Inc, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. Its telephone number is 781-751-6005 and website is www.mib.com.

POLICY LIMITATIONS

In the case of suicide, while sane or insane, within two years from the issue date of the policy, the benefit is limited to a refund of premiums paid.

- **For Guaranteed Acceptance Life**, if death occurs within two years from the policy issue date and is due to non-accidental causes (other than suicide), the death benefit will be equal to the premiums paid.
- **For Deferred Life**, if death occurs within two years from the policy issue date and is due to non-accidental causes (other than suicide), the death benefit will be equal to the premiums paid plus 3% interest.
- **For Deferred Elite Life and Deferred Elite Term**, if death occurs within two years from the policy issue date and is due to non-accidental causes (other than suicide), the death benefit will be equal, in the first year, to the premiums paid plus 3% interest and, in the second year, to 50% of the face amount.
- **For Accidental Death Benefit**, the benefit payable may be limited by factors such as the Insured's age and the cause of death. Please see your policy for detailed terms and conditions.

The policy that may be issued as a result of this application has important terms and limitations. You should review it carefully as soon as you receive it.

RECEIPT

(Detach and present to Owner ONLY if a cheque was provided for payment of the first annual premium.)

Foresters Life Insurance Company acknowledges the receipt of $.................... to be applied in payment of the first premium for

insurance on the life of ....

Insurance coverage commences on the date the application is approved subject to the initial premium being honoured when first presented for payment to the financial institution from which payment is to be made.

If the policy is not received within six (6) weeks of the date of this receipt, please contact Canada Protection Plan at the address on the back cover.

Dated at .... this .... day of .... , 20..........
City / Province

The Owner has the right to cancel the Policy issued and receive a full refund of premium paid for it by notifying the Insurer in writing and returning the policy within 10 days of first receiving it.

Thank you for placing your trust in Canada Protection Plan, providing you with peace of mind.

Along with reliable support and compassionate service, there are many other advantages to apply:

- ✓ Payments start in the second month - applicable on monthly payment plans only
- ✓ You can apply for coverage up to $500,000 on many No Medical plans
- ✓ You can apply for coverage up to $1 million on all Preferred Plans
- ✓ If you are ages 18 to 80, you can apply
- ✓ Most of our term plans are renewable and convertible
- ✓ Low rates in comparison to similar plans and benefits

Canada Protection Plan is underwritten by Foresters Life Insurance Company of Canada, which is a member of Assuris and a subsidiary of Foresters (established in 1874).

You may qualify to enjoy a valuable package of member benefits.*

From an online document preparation service** for creating customizable wills and powers of attorney to competitive scholarships and more.

Information about member benefits can be found on the foresters.com website. After the policy has been issued and delivered, you can register at my.foresters.com to access many of the member benefits.

* *Foresters member benefits are non-contractual, subject to benefit specific eligibility requirements, definitions and limitations and may be changed or cancelled without notice or are no longer available.*

** *LawAssure online document preparation service is provided by Epoq, Inc. Epoq is an independent service provider and is not affiliated with Foresters. Not available in Quebec, the Yukon, the Northwest Territories and Nunavut. LawAssure is not a legal service or legal advice and is not a substitute for legal advice or services of a lawyer.*

We stand by you today, so your loved ones are protected for tomorrow.

A Foresters Financial™ Company

Distributed by
Canada Protection Plan
250 Ferrand Drive, Suite 1100
Toronto, Ontario
M3C 3G8

Tel: (416) 447-6060
Toll free: 877-447-6060
Fax: (416) 447-9881

cpp.ca

CANADA PROTECTION PLAN and the logo are trademarks of Canada Protection Plan Inc., a Foresters Financial Company, No Medical and Simplified Issue Life and Critical Illness Insurance Underwritten by Foresters Life Insurance Company. Used under licence.

Foresters Financial

Foresters Financial and Foresters are trade names and trademarks of The Independent Order of Foresters (a fraternal benefit society, 789 Don Mills Road, Toronto, Ontario, Canada M3C 1T9) and its subsidiaries, including Foresters Life Insurance Company.