Foresters Financial

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Short Reinstatement Form

Policy number:

Purpose of this form

Use this form to request a reinstatement of your policy. This form will be accepted if received within 30 days from the lapse date.

Terms used in this form

Foresters Financial™, *Insurer* or *We* mean The Independent Order of Foresters or Foresters Life Insurance Company.

You or your means the Owner(s) who is/are completing and signing this form, unless otherwise specified.
Policy means a certificate, annuity or policy issued by an Insurer and includes each rider that is attached.
Owner includes Policy Owner, Absolute Assignee and Annuitant.

Social Insurance Number will be known as SIN and Tax Identification Number will be known as TIN.

1. Policy Owner Information

Information about the current Owner(s)

Owner 1 Name (first, middle initial & last)

SIN/TIN | Date of Birth (mm/dd/yyyy) | Primary Phone Number

Owner 2 Name (If applicable) (first, middle initial & last)

SIN/TIN | Date of Birth (mm/dd/yyyy) | Primary Phone Number

2. Policy Insured Information

Information about the current Insured(s)

Only complete if different than Owner.

Insured 1 Name (first, middle initial & last)

SIN/TIN | Date of Birth (mm/dd/yyyy) | Primary Phone Number

Insured 2 Name (first, middle initial & last) (If applicable)

SIN/TIN | Date of Birth (mm/dd/yyyy) | Primary Phone Number

3. Payment

The current method of payment will resume. If you wish to make changes to the current method of payment please complete form number 413648.

Amount submitted with this Application:

4. Lifestyle and Medical Review

4.1 Lifestyle and Medical review questions for Insured 1

*For this section, "you" refers to the Insured.

1 a. Are you and your dependents (if insured under this policy as at the date of lapse) in good health? ○ Yes ○ No

If no, please provide details:

b. Are you and your dependents (if insured under this policy as at the date of lapse) free from impairments? ○ Yes ○ No

If no, please provide details:

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4. Lifestyle and Medical Review (continued)

2. Have you or any of your dependents (if insured under this policy as at the date of lapse) been ill or suffered an accident since the issue date of the policy? ○ Yes ○ No

   If yes, please provide details:

3 a. Have you or any of your dependents (if insured under this policy as at the date of lapse) consulted a physician since the issue date of the policy? ○ Yes ○ No

   b. If yes, name and address of physician consulted:

   c. Date consulted:

   d. Reason consulted:

   e. Results of consultation:

4. Has your occupation changed since the issue date of the policy? ○ Yes ○ No

   If yes, what is your present occupation?:

5. Have you smoked cigarettes or used any tobacco products in the past two years? ○ Yes ○ No

4.2 Lifestyle and Medical review questions for Insured 2/Spouse

*For this section, "you" refers to the Insured.

1 a. Are you and your dependents (if insured under this policy as at the date of lapse) in good health? ○ Yes ○ No

   If no, please provide details:

   b. Are you and your dependents (if insured under this policy as at the date of lapse) free from impairments? ○ Yes ○ No

   If no, please provide details:

2. Have you or any of your dependents (if insured under this policy as at the date of lapse) been ill or suffered an accidentsince the issue date of the policy? ○ Yes ○ No

   If yes, please provide details:

3 a. Have you or any of your dependents (if insured under this policy as at the date of lapse) consulted a physician since the issue date of the policy? ○ Yes ○ No

   b. If yes, name and address of physician consulted:

   c. Date consulted:

   d. Reason consulted:

   e. Results of consultation:

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4. Lifestyle and Medical Review (continued)

4. Has your occupation changed since the issue date of the policy? ○ Yes ○ No

   If yes, what is your present occupation?:

5. Have you smoked cigarettes or used any tobacco products in the past two years? ○ Yes ○ No

5. Agreements and Authorizations

Please review this section before signing.

I, the Insured and/or Owner do hereby request that consideration be given to reinstating my policy and accept the premium thereon, which has not been paid, and to thereby again establish said policy in full force and effect. Should this reinstatement be for my Accident and Health and/or Hospitalization policy, I hereby understand that upon approval of this application for reinstatement, only losses resulting from an accidental injury that occurs after the date of reinstatement, or any losses due to such sickness as may begin more than ten (10) days after the reinstatement date.

I further declare that the above questions have been answered to the best of my knowledge and ability; and that the answers given are deemed to be representation and not warranties.

6. Signature Section

Owner(s) Signature

Initial

If the Owner is a company, please have two officers sign, or one officer with corporate seal. If you are the only signing officer and there is no corporate seal, please sign below, and initial the box to the left to confirm.

Owner 1 - Please print name, and title if signing for a company

Signature of Owner 1

X

Signed at City, Province/Territory

Date (mm/dd/yyyy)

Owner 2 - Please print name, and title if signing for a company (if applicable)

Signature of Owner 2

X

Signed at City, Province/Territory

Date (mm/dd/yyyy)

Insured(s) Signature

Insured 1 - Please print name, and title if signing for a company

Signature of Insured 1

X

Signed at City, Province/Territory

Date (mm/dd/yyyy)

Insured 2 - Please print name, and title if signing for a company (if applicable)

Signature of Insured 2

X

Signed at City, Province/Territory

Date (mm/dd/yyyy)

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