

# Canada Protection Plan™

## Application for Express Elite Term Insurance



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**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 permit to apply.  
The maximum amount for an Insured on a work permit is \$250,000.

|                                                                                                                                |                        |                                                                                              |                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|
| Name .....<br>First Middle Last                                                                                                |                        |                                                                                              | Male<br>Female                                                                         |  |
| Date of Birth .....<br>MM / DD / YY                                                                                            | Country of Birth ..... | Canadian Citizen <sup>1</sup><br>Permanent Resident <sup>1</sup><br>Work Permit <sup>1</sup> | Telephone<br>Primary .....                                                             |  |
| Address .....<br>Street Name & Number Apartment Number<br>City / Town Province/Territory Postal Code                           |                        |                                                                                              | Work / Other .....                                                                     |  |
| Occupation .....                                                                                                               |                        |                                                                                              | Best date and time to call for verification, if applicable (be specific):<br>Date Time |  |
| Email (Required if insured is the owner) .....                                                                                 |                        |                                                                                              |                                                                                        |  |
| Driver's Licence (or Gov't Issued Photo ID # and Type)<br>Number (and type) Province/Territory of Issue Expiry Date (MM/DD/YY) |                        |                                                                                              | Are you a Foresters member?<br>Yes No, applying for membership                         |  |

**OWNER**

Complete Owner details only if different than Insured

- 2 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.

|                                                                                                                                |                                                                        |                               |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------|
| Owner is: Insured<br>Other - complete this section                                                                             | Full Legal Name of Individual or Corporation/Entity <sup>2</sup> ..... | Relationship to Insured ..... |
| Address .....<br>Street Name & Number Apartment Number City / Town Province/Territory Postal Code                              |                                                                        |                               |
| Email (Required) .....                                                                                                         | Telephone .....<br>Primary Work / Other                                |                               |
| If Individual: Occupation .....                                                                                                | Date of Birth .....<br>MM / DD / YY                                    |                               |
| Driver's Licence (or Gov't Issued Photo ID # and Type)<br>Number (and type) Province/Territory of Issue Expiry Date (MM/DD/YY) |                                                                        |                               |

**CONTINGENT OWNER**

|                                                           |                             |
|-----------------------------------------------------------|-----------------------------|
| Full Legal Name of Individual 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)<br>Irrevocable (I) | Primary (P)<br>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 .....<br>MM / DD / YY |
| Address .....<br>Street Name & Number Apartment Number City / Town Province/Territory Postal Code |                                     |

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

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

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <p><b>1</b>   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 four times per week? .....</p> <p><i>If YES, smoker rates applicable.</i></p>                                                                                                              | <p>Yes    No</p> |
| <p><b>2</b>   Will premiums be stopped, or coverage be reduced or discontinued, on existing life insurance coverage or annuity if the insurance applied for in this application is issued? .....</p> <p><i>If YES, state insurer, amount and plan, and complete the Comparison Disclosure Statement or Life Insurance Replacement Declaration required in your province.</i></p> <p>Insurer ..... Amount ..... Plan .....</p> | <p>Yes    No</p> |

**QUALIFICATION QUESTIONS**

**YES** If a question is answered YES in this section, **DO NOT PROCEED.** Please apply for one of Canada Protection Plan's A-Z Life Coverage products.

**NO** If ALL NO answers are provided, continue to Coverage Details section

|                                                                                                                                                                                                                                                                                                                                                                                                    |                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <p><b>1</b>   Are you presently undergoing or waiting to have surgery or an investigation or diagnostic test of any type, or to consult with a medical institution, specialist or medical professional that has not yet been completed? .....</p>                                                                                                                                                  | <p>Yes    No</p> |
| <p><b>2</b>   Have you been advised of any abnormal test results within the last 60 days? .....</p>                                                                                                                                                                                                                                                                                                | <p>Yes    No</p> |
| <p><b>3</b>   Have you been an inpatient in the hospital for greater than 48 hours within the last 60 days? .....</p>                                                                                                                                                                                                                                                                              | <p>Yes    No</p> |
| <p><b>4</b>   Have you ever been advised to receive, are you on a waiting list for, or are you the recipient of, an organ or bone marrow transplant (excluding corneal transplants)? .....</p>                                                                                                                                                                                                     | <p>Yes    No</p> |
| <p><b>5</b>   Do you require the use of a wheelchair for chronic illness or disease? .....</p>                                                                                                                                                                                                                                                                                                     | <p>Yes    No</p> |
| <p><b>6</b>   Within the last 12 months, has there been any change in your medication (increased or decreased), or have you been prescribed a new medication for a chronic condition? .....</p>                                                                                                                                                                                                    | <p>Yes    No</p> |
| <p><b>7</b>   Have you ever had, been told you have, been treated for, or been advised to have surgery, an investigation or diagnostic test, that has not yet started or been completed or the results of which are not yet known, for:</p>                                                                                                                                                        |                  |
| <p>a. Cancer, an abnormal growth or a malignant tumor? .....</p>                                                                                                                                                                                                                                                                                                                                   | <p>Yes    No</p> |
| <p>b. Anemia, bleeding disorders or a disease or disorder of the blood? .....</p>                                                                                                                                                                                                                                                                                                                  | <p>Yes    No</p> |
| <p>c. Cystic Fibrosis or a chronic respiratory condition (excluding asthma not requiring ongoing use of steroids) such as but not limited to emphysema or Chronic Obstructive Pulmonary Disease (COPD), or used, or been advised to use, oxygen equipment to assist with breathing (excluding use for sleep apnea)? .....</p>                                                                      | <p>Yes    No</p> |
| <p>d. A disease or disorder of the central nervous system such as but not limited to, Dementia, Alzheimer's, Muscular Dystrophy, Huntington's Chorea, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, epilepsy or multiple sclerosis (MS)? .....</p>                                                                                                                                             | <p>Yes    No</p> |
| <p>e. Cardiac chest pain (angina), heart attack (myocardial infarction), coronary artery disease, stroke (CVA), congestive heart failure, cardiomyopathy, valvular disease or disorder, heart rhythm disorder, peripheral vascular disease, aneurysm, circulatory disorder or more than one transient ischemic attack (TIA) or had heart bypass surgery, angioplasty or stent insertion? .....</p> | <p>Yes    No</p> |
| <p>f. A disease or disorder of the genito-urinary system such as but not limited to sugar (glucose), protein (albumin) or pus in the urine, a disease or disorder of a kidney, bladder, ovaries, uterus, breast or prostate? .....</p>                                                                                                                                                             | <p>Yes    No</p> |
| <p>g. A disease or disorder of the endocrine system such as but not limited to diabetes, thyroid or glandular disease or disorder? .....</p>                                                                                                                                                                                                                                                       | <p>Yes    No</p> |
| <p>h. Liver disease or disorder such as but not limited to cirrhosis or hepatitis (excluding Hepatitis A or B) or a disease or disorder of the pancreas? .....</p>                                                                                                                                                                                                                                 | <p>Yes    No</p> |
| <p>i. Acquired Immunodeficiency Syndrome (AIDS) or have you tested positive for Immunodeficiency virus (HIV) or a disease or disorder of the immune system? .....</p>                                                                                                                                                                                                                              | <p>Yes    No</p> |
| <p>j. A disease or disorder of the gastrointestinal system such as but not limited to the bowels, esophagus, Crohn's Disease or ulcerative colitis? .....</p>                                                                                                                                                                                                                                      | <p>Yes    No</p> |
| <p>k. Bipolar disorder, schizophrenia or psychosis? .....</p>                                                                                                                                                                                                                                                                                                                                      | <p>Yes    No</p> |
| <p>l. A mental or nervous disease or disorder, such as but not limited to depression or anxiety for which you had a hospital stay, missed time from work or suicide attempt or suicidal thought? .....</p>                                                                                                                                                                                         | <p>Yes    No</p> |
| <p>m. A disease or disorder of the skin (excluding seasonal allergies or seasonal allergic reactions), bones or joints such as but not limited to inflammatory arthritis, rheumatoid arthritis, psoriatic arthritis or polymyalgia rheumatic requiring treatment other than nonsteroidal anti-inflammatory drugs or aspirin? .....</p>                                                             | <p>Yes    No</p> |

**QUALIFICATION QUESTIONS (CONTINUED)**

**YES** If a question is answered **YES** in this section, **DO NOT PROCEED.** Please apply for one of **Canada Protection Plan's A-Z Life Coverage products.**

**NO** If **ALL NO** answers are provided, continue to **Coverage Details section**

- 8 |** Within the past 5 years have you:
- a. 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, or have you used methadone or fentanyl whether prescribed by a physician or not? ..... **Yes No**
  - b. Been treated for or received medical advice or counselling for the use of drugs or alcohol? ..... **Yes No**
- 9 |** Within the past 2 years have you:
- a. Been involved in the operation of an aircraft as a pilot (scheduled commercial pilots excluded), or do you plan to participate in aviation within the next 12 months? ..... **Yes No**
  - b. Been involved in any hazardous sports, such as but not limited to scuba diving, motor vehicle racing, mountain climbing, back country skiing, sky diving, or do you plan to do so within the next 12 months? ..... **Yes No**
  - c. Had your driver's license suspended or revoked or have you had more than three moving violations within the past 12 months? ..... **Yes No**
- 10 |** Within the past 10 years, have you been convicted of, awaiting sentencing for, incarcerated for, or on probation or parole, for a criminal offence, or do you currently have a criminal charge pending (excluding a single DUI)? ..... **Yes No**
- 11 |** 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) or has any member of your immediate family been treated for or been diagnosed with polycystic kidney disease, Huntington's Chorea or a hereditary disease or disorder, before the age of 60? ..... **Yes No**
- 12 |** Do you plan to travel outside North America, the Caribbean, the United Kingdom or the European Union countries for more than 12 consecutive weeks in the next 12 months? ..... **Yes No**
- 13 |** Have you had a weight loss of 10% or more of body weight within the past 12 months other than due to intentional dieting? ..... **Yes No**
- 14 |** Is your weight outside the range showing for your height in the following table? ..... **Yes No**

|                     |           |           |           |           |           |           |
|---------------------|-----------|-----------|-----------|-----------|-----------|-----------|
| <b>Height</b>       | 4'8"      | 4'9"      | 4'10"     | 4'11"     | 5'0"      | 5'1"      |
| <b>Weight (lbs)</b> | 79 - 135  | 81 - 139  | 84 - 144  | 87 - 150  | 90 - 157  | 93 - 163  |
| <b>Height</b>       | 5'2"      | 5'3"      | 5'4"      | 5'5"      | 5'6"      | 5'7"      |
| <b>Weight (lbs)</b> | 96 - 168  | 99 - 174  | 102 - 180 | 106 - 185 | 109 - 190 | 112 - 196 |
| <b>Height</b>       | 5'8"      | 5'9"      | 5'10"     | 5'11"     | 6'0"      | 6'1"      |
| <b>Weight (lbs)</b> | 116 - 203 | 119 - 210 | 122 - 215 | 126 - 220 | 129 - 227 | 133 - 234 |
| <b>Height</b>       | 6'2"      | 6'3"      | 6'4"      | 6'5"      | 6'6"      | 6'7"      |
| <b>Weight (lbs)</b> | 137 - 241 | 140 - 248 | 144 - 255 | 148 - 261 | 152 - 269 | 156 - 276 |

## 03 Coverage Details

## Application for Express Elite Term Insurance

### 1 One term insurance rider

>> 20 Year Term Rider is only available on Term 30 base plan

### 2 Complete Child Term Benefit questions

| Term Insurance Plan                                  | Term Period          | Amount of Insurance |           |          |  |
|------------------------------------------------------|----------------------|---------------------|-----------|----------|--|
| Express Elite Term                                   | 20 Year (Ages 18-60) | \$ .....            |           |          |  |
|                                                      | 30 Year (Ages 18-50) |                     |           |          |  |
| Optional Riders                                      | Amount               |                     |           |          |  |
| 20 Year Term Rider <sup>1</sup> (Ages 18-50)         | \$ .....             |                     |           |          |  |
| Accidental Death Benefit (Ages 18-60)                | \$ .....             |                     |           |          |  |
| Child Term Benefit <sup>2</sup> (Parent: Ages 18-60) | \$5,000              | \$10,000            | \$15,000  | \$20,000 |  |
| Hospital Cash Benefit (Ages 18-60)                   | \$25/day             | \$50/day            | \$100/day |          |  |

## 04 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

## 05 Premium Details

## Application for Express Elite Term Insurance

### 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                                                                                   | <b>Cheque.</b> Payable to Foresters Life Insurance Company; annual payment only.<br><b>Pre-Authorized Debit (PAD).</b> Monthly payment only; complete PAD Plan Agreement on page 6.<br><b>Credit Card.</b> Annual payment only; complete Credit Card Payment Details below. |               |                           |                       |
| Payment method for initial premium for annual payment, if different than payment method indicated above. | Initial premium for payment must be provided with this Application if annual payment method is chosen.                                                                                                                                                                      |               |                           | Cheque<br>Credit Card |
| <b>CREDIT CARD PAYMENT DETAILS</b> Complete this section ONLY if paying ANNUALLY by credit card.         |                                                                                                                                                                                                                                                                             |               |                           |                       |
| Card Type:                                                                                               | Cardholder name as it appears on the card                                                                                                                                                                                                                                   |               |                           |                       |
| VISA      MASTERCARD                                                                                     | .....                                                                                                                                                                                                                                                                       |               |                           |                       |
| Card Number                                                                                              | Expiry Date                                                                                                                                                                                                                                                                 | Signature     |                           |                       |
| .....                                                                                                    | .....                                                                                                                                                                                                                                                                       | .....         |                           |                       |

## 06 Special Requests / Details

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

**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 (1 <sup>st</sup> – 28 <sup>th</sup> ) ..... |          |                                     |                                                                       |
| PAD bank account information to be taken from:                        |          | Attached VOID cheque                | Banking information below <i>(complete if cheque is not attached)</i> |
| Type of Account                                                       | Chequing | Savings                             | Transit # (5 digits) .....                                            |
| 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.cdnpay.ca](http://www.cdnpay.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.cdnpay.ca](http://www.cdnpay.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 Agreements and Authorizations.

“Application” means this Canada Protection Plan Application for Express Elite Term 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, offering products and services; business analysis and operations; 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 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**

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

**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 Advisor .....

The owner or the insured, if the insured is the owner, signed in ..... on .....  
Province/Territory (MM/DD/YYYY)

# Advisor's Report

| ADVISOR INFORMATION | Advisor Name <i>(first, middle, last)</i> | 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:*

## 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 satisfied the Owner's requirements with a suitable product. 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](mailto: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 [www.cpp.ca](http://www.cpp.ca) and [www.foresters.com](http://www.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, 330 University Avenue, Toronto, Ontario M5G 1R7. Its telephone number is (416) 597-0590 and website is [www.mib.com](http://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 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.

## R E C E I P T

(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
- ✓ Express Elite offers No Medical coverage up to \$500,000
- ✓ Ages 18 to 60 can apply for Express Elite Term Plans
- ✓ Very competitive rates
- ✓ A simple and easy application process getting you covered quickly

*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).*

As a policyholder, you may be eligible to enjoy a valuable package of complimentary benefits.\*

When you receive your policy, all complimentary benefits will be outlined. The following are just a few of these benefits:

- ✓ Emergency assistance program providing short term financial assistance
- ✓ Orphan benefits of \$900 monthly per child up to age 18
- ✓ Everyday money toll free financial help line providing counselling
- ✓ Terminal illness loan up to 75% of your coverage to a maximum of \$250,000
- ✓ Competitive Scholarship program can provide up to \$8,000 each for postsecondary education
- ✓ Foresters Community Grants providing additional funding to your community projects

\* Some of the benefits listed are available, at no charge, to eligible Foresters policyholders with an insurance plan of \$10,000 or more; they are offered to the insured under a policy, are non-contractual, subject to benefit specific eligibility requirements, definitions and limitations and may be changed or cancelled without notice.

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



*Distributed by*

**Canada Protection Plan**

250 Ferrand Drive, Suite 1100  
Toronto, Ontario  
M3C 3G8

[www.cpp.ca](http://www.cpp.ca)

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**Foresters Life Insurance Company**

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**Foresters**  
Financial