

### Application to Add Hospital Cash

#### Section A – Policy Information

<b>Policy Number:</b>	<b>Life Insured's Name:</b>	<b>Date of Birth (MM/DD/YYYY)</b>
<b>Address:</b>		<b>Telephone Number</b>

#### Section B - Request

**Please add a Hospital Cash Rider to the above identified policy to be effective once underwriting is completed and this application is approved.**

**Amount:**  \$25/day  \$50/day  \$100/day

*If ANY question in this section "Determining Eligibility for Coverage" is answered "Yes", coverage is NOT available*

	Yes	No
<b>1. Within the past THREE YEARS, have you had or been treated for:</b>		
a) heart failure or peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) cancer or malignant tumour?	<input type="checkbox"/>	<input type="checkbox"/>
c) unusual chronic infection or Immune System abnormality including HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
d) an incurable terminal illness?	<input type="checkbox"/>	<input type="checkbox"/>
e) organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Are you currently hospitalized or confined to a nursing facility?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Within the past TWO YEARS, have you had or been treated for:</b>		
a) heart attack, stroke, bypass surgery or coronary artery disease requiring hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>
b) angina or severe chest pains requiring hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>
c) high blood pressure not controlled by medication and/or a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
d) serious blood disorders such as hemophilia, thrombocytopenia or serious anemia?	<input type="checkbox"/>	<input type="checkbox"/>
e) chronic respiratory condition which required the administration of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
f) chronic kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
g) chronic liver disease such as hepatitis B or C and cirrhosis?	<input type="checkbox"/>	<input type="checkbox"/>
h) Alzheimer's disease, dementia, multiple sclerosis or suicide attempts?	<input type="checkbox"/>	<input type="checkbox"/>
i) alcoholism or drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>
j) diabetes requiring daily insulin injections?	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Within the past TWO YEARS, have you applied for life insurance, which has been declined or postponed?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Within the past SIX MONTHS, have you had any medical tests done for which a diagnosis has not yet been reached?</b>	<input type="checkbox"/>	<input type="checkbox"/>

### Section C - Declaration and Authorization

**I declare and agree that:**

All statements, representations and answers provided, together with any other additional evidence as may be required by Foresters Life Insurance Company (the “Company”), are true, full and complete, and are a consideration for and a basis of the change being requested.

I understand that if I do not fully, completely and truthfully answer the above questions (if I misrepresent my answers or statements), the Company may void the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic, MIB Inc. or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company or its reinsurer(s) any such information.

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

I authorize the Company to make a brief report about my health to MIB Inc., even if this application is cancelled or withdrawn.

Location signed (City & Province)	Date (MM/DD/YYYY)	Signatures
		<b>Life Insured</b>
		<b>Owner (if other than Life Insured)</b>
		<b>Witness/Agent</b>

**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)