Foresters critical illness insurance

Live Well and Live Well Plus Advisor Guide

Foresters Financial

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Critical illness insurance

This guide is intended to answer your questions and provide ideas to help you sell Live Well[1] and Live Well Plus.[1] It is for information purposes only. You must ensure that you correctly represent, to a customer or prospect, the product features based on the wording of the applicable policy and riders. You can view a sample policy at foresters.com/en-ca/for-advisors/sample-contracts.aspx, or contact your Foresters Regional Vice President or our Inside Sales Support Team at InsideSalesCanada@foresters.com. This document is intended for advisor use only and should not be disclosed to the public. The information contained in this guide is general in nature and is subject to the applicable policy and rider wording. This guide includes some of our current administrative rules. These rules are not contractual and are subject to change.

Foresters Financial™, its employees and life insurance representatives do not provide, on Foresters behalf, legal, tax, or estate planning advice. The information here reflects our understanding of current laws and regulations. Prospective purchasers should contact their own legal, tax or estate planning advisors on their specific situations.

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Live Well and Live Well Plus product details

Live Well and Live Well Plus provide a lump sum benefit, which may pay out after the diagnosis/confirmation of a covered critical illness condition. Live Well has been designed for Canadians looking for simple and affordable basic critical illness insurance or who want to have critical illness insurance protection without going through extensive health underwriting. Live Well Plus has been designed for Canadians who would like comprehensive critical illness insurance coverage due to more covered conditions or who may not qualify for Live Well because of their medical or family history.

The chance of surviving after the diagnosis of a serious illness has improved due to medical advances. As a result, there is a growing need for insurance protection geared to assist an individual's financial recovery while they focus on their physical recovery after the onset of a critical illness covered condition.

Coverage options

Live Well and Live Well Plus are available with the following coverage options:

– Live Well Term 10	– Live Well Plus Term 10
– Live Well Term 20	– Live Well Plus Term 20
– Live Well Term to Age 80	– Live Well Plus Term to Age 80

Benefits

Live Well and Live Well Plus are available with the following the following issue limits:

Plan	Minimum	Maximum
Live Well	$25,000	$100,000
Live Well Plus	$25,000	$2,000,000

Issue Ages (age nearest birthday)

Live Well and Live Well Plus are available at the following issue ages:

Plan	Issue Ages	Plan	Issue Ages
Live Well Term 10	18-55	Live Well Plus Term 10	18-65
Live Well Term 20	18-55	Live Well Plus Term 20	18-55
Live Well Term to Age 80	18-55	Live Well Plus Term to Age 80	18-65

Critical illness covered conditions

Condition	Live Well	Live Well Plus
Aortic surgery		✓
Aplastic anemia		✓
Bacterial meningitis		✓
Benign brain tumour		✓
Blindness		✓
Cancer	✓	✓
Coma		✓
Coronary artery bypass surgery	✓	✓
Deafness		✓
Dementia, including Alzheimer's disease		✓
Heart attack	✓	✓
Heart valve replacement or repair		✓
Kidney failure		✓
Loss of Independent Existence		✓
Loss of limbs		✓
Loss of speech		✓
Major organ failure on waiting list		✓
Major organ transplant		✓
Motor neuron disease		✓
Multiple sclerosis		✓
Occupational HIV infection		✓
Paralysis		✓
Parkinson's disease and specified atypical Parkinsonian disorders		✓
Severe burns		✓
Stroke	✓	✓

For a full description and definitions of these covered conditions, please see Appendix A. This Guide is a summary of benefits, payments and some of the contractual rights, subject to the terms and conditions of the applicable policy.

Survival period

Provided the insured survives for 30 days and has not experienced irreversible cessation of all functions of the brain, a lump sum benefit may be payable after the diagnosis of, or surgery for, one of the critical illness covered conditions.

Some covered conditions may have additional time elements (see Appendix A). For example:

- requires having bacterial meningitis for 90 days with loss-of-independent existence and paralysis
- 6 months for dementia, including Alzheimer's disease
- 1 year for Parkinson's disease
- The number of days until the serum HIV tests are taken as specified in the definition for occupational HIV infection

Non-life-threatening Illness benefit

We may pay the non-life-threatening illness benefit amount upon our receipt of evidence, satisfactory to us, that the insured has:

a) Been diagnosed with, or undergone, a non-life-threatening illness covered condition, while the policy is in effect; and
b) Survived to the end of the survival period.

The non-life-threatening illness benefit amount is the lesser of:
a) 15% of the benefit amount; and
b) $50,000.

The non-life-threatening illness benefit is payable a maximum of two (2) times, provided each payment must occur for a different non-life-threatening illness benefit covered condition. Payment of the non-life-threatening illness benefit will not cause the policy to end. The benefit amount will be reduced by the amount of each payment of the non-life-threatening illness benefit.

The non-life-threatening illness benefit will not be payable if any non-life-threatening illness covered condition occurs during the survival period for a covered condition, unless the insured does not complete that survival period.

The non-life-threatening illness covered conditions are:

- Coronary angioplasty
- Ductal breast cancer in-situ
- Early chronic lymphocytic leukemia
- Early prostate cancer
- Early thyroid cancer
- Gastrointestinal stromal tumours
- Grade 1 neuroendocrine tumours (carcinoid)
- Superficial malignant melanoma

For a full description of these conditions, please Appendix B

Example:
On September 23, 2021, the owner buys a $100,000 Live Well Plus Term to Age 80 policy. On July 15, 2032, the insured receives a written diagnosis of early prostate cancer. The payment of the non-life-threatening illness benefit will be $15,000.

Benefit amount x 15% = Non-life-threatening illness benefit

$100,000 x 15% = $15,000

The remaining benefit amount will be $85,000.

Return of Premium on Death Benefit

We may pay, the eligible premiums, without interest, minus the amount of each payment made by us under the Juvenile Critical Illness Insurance rider, upon our receipt of proof, satisfactory to us, of the insured's death. That death must occur while the policy is in effect. We will not pay the eligible premium if the benefit amount or a non-life-threatening illness benefit has been paid under the policy.

Eligible premiums mean the sum of the premiums received by us for the policy including substandard ratings plus premiums for each rider. Eligible premiums do not include:

a) premium amount due for the policy that is waived under any waiver of premium rider or similar benefit, or is otherwise waived by us
b) interest
c) policy fees or
d) premium paid for another policy even if this policy is an exchange from that other policy.

The Owner may designate one, or more than one, primary or contingent beneficiary, for the Return of Premium on Death benefit. Each initial primary and contingent beneficiary, if any, is named in the application. If no beneficiary survives the insured or if no beneficiary is designated, this payment will be made to the Owner or the Owner's estate.

Example:
On September 23, 2021, the owner buys a $40,000 Live Well Term to Age 80 policy with an annual premium of $500.

On October 4, 2035, the insured passes away from injuries sustained in a car accident. There have been no changes to the policy between Sept. 23, 2021 and October 4, 2035. The payable eligible premium amount would be $7,500 and the policy would be terminated.

Annual premium x Number of premiums paid = Benefit

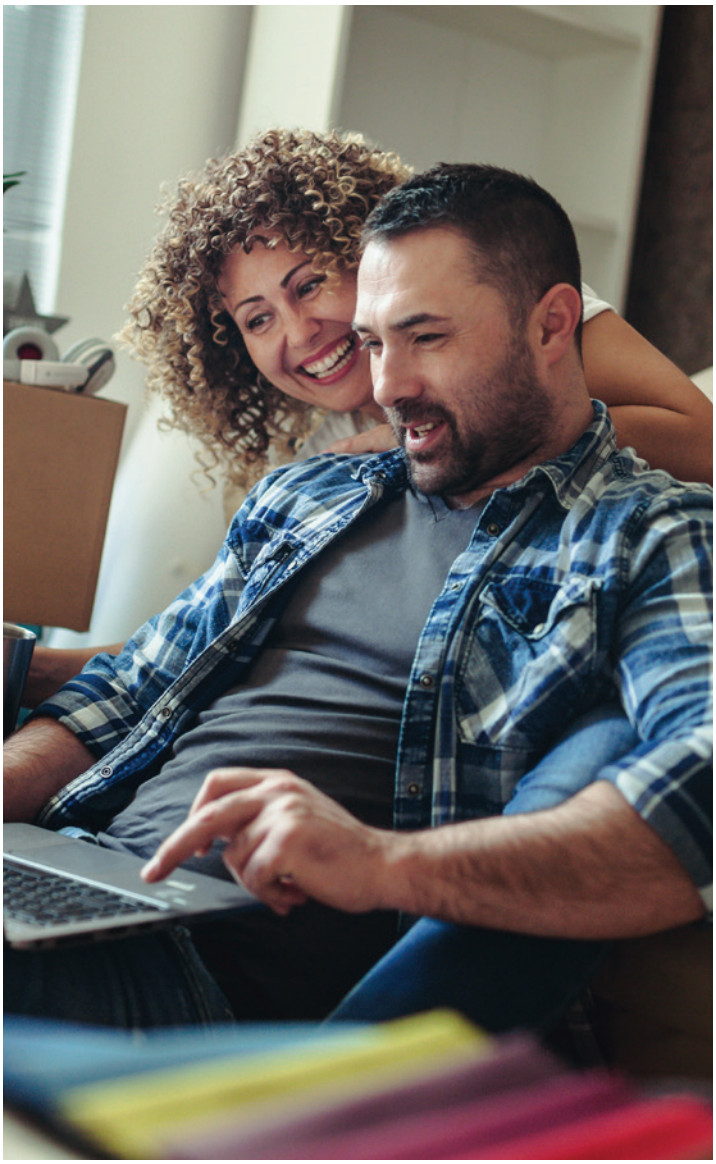
$500 x 15 = $7,500

Termination

A policy will remain in effect until the earliest of the following dates:

a) The policy anniversary on which the insured is age 80;
b) The date the insured dies;
c) The effective date of surrender, as shown in our records, arising from a request to surrender the policy;
d) The date the policy lapses, as described in the Grace Period provision.
e) The date that the benefit amount is paid.

This policy will end and not be in effect after the earliest of the above dates which means our liability under it will end on that date.



Premiums and premium payments

Premium bands	**Plan** Live Well Live Well Plus	**Band 1** $25,000 - $100,000 $25,000 - $100,000	**Band 2** $100,001 - $250,000	**Band 3** $250,001+
Modal factors	Foresters offers premium payment frequencies other than yearly. Each payment frequency other than yearly will result in a higher premium than paying annually. The modal factors are:			
	Monthly PAC: 0.09	**Quarterly:** 0.27	**Semi-annual:** 0.54	
Policy fee	There are no policy fees for Live Well or Live Well Plus policies.			
Grace period	We will allow a period of 31 days after the premium due date for payment of each subsequent total premium after the first total premium is paid as due. If the total premium due is still unpaid at the expiration of the grace period, the policy will automatically lapse. If the insured is diagnosed with, or undergoes, a covered condition or non-life-threatening covered condition during the grace period and the claim is approved, we will deduct unpaid premium from the benefit amount payable. No benefit is payable for a covered condition, or a non-life-threatening illness covered condition, that is diagnosed, or undergone, while the policy is not in effect.			
Reinstatement	A policy may be reinstated within two years of the effective date of lapse. Reinstatement requires: 1) a signed application; 2) evidence of insurability of a) the good health and b) other aspects of the insurability of the insured; and 3) payment of the unpaid premium plus interest, at the lower of the rate determined by us or as prescribed by applicable law. The unpaid premium will be the sum of: a) The total premiums due but not paid in full on or before the effective date of lapse; plus b) The total premiums that would have been due, from the effective date of lapse to the effective date of reinstatement, if the policy had not lapsed. Reinstatement is subject to our approval. If we approve reinstatement of this policy, the moratorium period and the two-year contestability period will begin anew from the effective date of reinstatement.			

Other policy features

Exchanges

Available exchanges:	
Existing plan	**Available plan(s)**
Live Well Term 10	Live Well Term to Age 80
Live Well Term 20	Live Well Term to Age 80
Live Well Term to Age 80	None
Live Well Plus Term 10	Live Well Plus Term to Age 80
Live Well Plus Term 20	Live Well Plus Term to Age 80
Live Well Plus Term to Age 80	None

The Exchange Privilege is available on or after the second (2nd) policy anniversary, and will be processed without evidence of insurability, subject to our administrative rules and the following conditions:

a) The owner must submit a written request for exchange to us, no sooner than thirty (30) days before the second (2nd) policy anniversary.
b) Premiums must be paid to the effective date of the exchange.
c) If the owner is requesting an exchange for a Live Well or Live Well Plus Term to Age 80 policy, the exchange must occur prior to the earlier of the fifth (5th) policy anniversary, and the policy anniversary nearest the insured's fifty-fifth (55th) birthday.
d) The policy cannot be exchanged if it was issued under the Exchange Privilege of a previous critical illness insurance policy.
e) The policy cannot be exchanged while premiums are being waived under a Disability Waiver of Premium Rider. This Exchange Privilege cannot be extended should the privilege expire while premiums are being waived.

The policy exchanged will end on the date the new policy takes effect under the exchange privilege. The following conditions will apply to the new policy:

1) The new policy will be the Live Well or Live Well Plus Term to Age 80 we offer at the time of the exchange.
2) Policy years under the new policy will be calculated from the policy date of the new policy.
3) The conditions and provisions of the new policy will apply from the date the new policy takes effect, except that our right to contest the validity of the new policy will continue to apply from the later of the effective date or the last reinstatement date of the policy being exchanged.
4) The evidence of insurability, including the application for the exchanged policy and the application for reinstatement, if any, of the exchanged policy will become part of the new policy and can be relied upon by us to contest the new policy.
5) In addition to each exclusion in the new policy, each exclusion in the exchanged policy will become part of the new policy.
6) The benefit amount under the new policy cannot exceed the benefit amount under the exchanged policy at the time of exchange and is subject to the minimum amount we allow for the new policy.
7) Each rider included in the exchanged policy may be included in the new policy if we offer it with the new policy. A new rider may be included in the new policy only with our consent and may be subject to evidence of insurability.
8) The premium rates applicable to the insured under the new policy will be based on:
   a. The benefit amount under the new policy and each of its riders, if applicable;
   b. The insured's attained age on the effective date of the exchange;
   c. The premium rates then in effect for the new policy and each of its riders, if applicable;
   d. The insured's rating class used in calculating the premiums for this policy and each of its riders, if applicable; and
   e. The insured's applicable insurance class used in calculating the premiums for this policy and each of its riders, if applicable.

Insurance class changes

The owner may submit a written request after a policy is in effect to change the insured's insurance class from a smoker class to a non-smoker class. We will consider such a request no more than once per year. This request is subject to our administrative rules and the following conditions:

1) We offer non-smoker premium rates at the time of the request.
2) The owner submits evidence of insurability we consider satisfactory as to the smoking habit of the insured, including our smoking habits declaration. The insured must meet our definition of a non-smoker at the time of the request.
3) The owner submits other evidence of insurability requested by us, such as but not limited to, a completed non-medical declaration of health for the insured in a form acceptable to us, as well as other medical evidence we might request, and such form and evidence is satisfactory to us.
4) We reserve the right to request payment of a fee we set from time to time for underwriting expenses. We will advise the owner of the amount of this fee before we process a request.

A change of insurance class will be effective on the effective date as shown in our records. We will adjust the premiums effective on that day, based on the issue age in effect on the policy date.

Reducing the Benefit Amount

The owner may request that we reduce the benefit amount, subject to our administrative rules and the following conditions:

– Premiums are paid to the effective date of the reduction.
– The minimum decrease allowed is $10,000, and the remaining benefit amount must not be less than the minimum specified in our administrative rules.

The reduced benefit amount will be effective on the effective date as shown in our records. We will adjust the premiums effective on that day.

General exclusions

In addition to the specific exclusions in the Covered Conditions, Non-Life-Threatening Illness Covered Conditions and the Juvenile Covered Conditions, if applicable, no benefit amount or non-life-threatening illness benefit amount or juvenile critical illness benefit amount will be payable if the covered condition, non-life- threatening illness covered condition or the juvenile covered condition results, directly or indirectly, from any of the following :

a) Attempted suicide or intentionally self-inflicted injuries, whether or not the insured has a mental illness or understands or intends the consequences of their action(s);
b) Voluntary participation in a riot or civil commotion.
c) Committing or attempting to commit a felony.
d) Involvement in an illegal occupation.
e) War or act of war, whether declared or undeclared.
f) Exposure to abnormal hazards because of service in the armed forces of any country or association of countries, whether war is declared or not and whether on active duty or not.
g) The intentional administration, injection, or taking of a drug, hypnotic or narcotic, unless administered on the advice of, and at the frequency and dosage prescribed by, a physician or, in the case of a legal, non-prescribed drug, as recommended by the drug manufacturer.

h) A motorized vehicle accident if the insured was the operator of the motorized vehicle and one or more of the following exists:
   a. A test or report completed by or at the direction of a medical professional, coroner, law enforcement, government agency or representative, based on a sampling obtained from the body of the insured within 24 hours of the accident, indicates the presence of either or both of the following:
      i. A narcotic in the body of the insured, regardless of the measurement or quantity.
      ii. A concentration of alcohol or tetrahydrocannabinol (TCH) in the insured's blood in excess of the quantity specified in the applicable legislation, where the accident occurred, as an offense for the operation of that type of motorized vehicle.
   b. A medical professional, coroner, law enforcement or government report indicates that, as a result of testing, it was determined that the insured was operating the motorized vehicle while impaired, intoxicated or under the influence of alcohol or an intoxicant, above the legal limit, where the accident occurred, or a narcotic.

For purposes of exclusion (h) a narcotic does not include a prescribed or legal, non-prescribed drug that was consumed by the insured as recommended by the drug manufacturer and, if a prescribed drug, as instructed by the licensed physician who prescribed, and pharmacy that dispensed, that drug, including restrictions related to the operation of a motorized vehicle.

In addition to the above, if a policy was issued as the result of exercising an exchange privilege, the exclusions under the policy exchanged from will apply to that policy.

Cancelling a policy or a rider

An owner can cancel a policy or a rider by written request to us. The effective date of the cancellation will be the effective date as shown in our records.

We will refund the unused portion of the premium except we will not refund premium if the last payment mode was monthly.

Optional benefit riders

This Guide is a summary of the optional benefit riders. Refer to the applicable rider for terms and conditions for full details, which governs in the event of a discrepancy with this Guide.

Disability Waiver of Premium Benefit

Insured's issue age: 18-55

This benefit will automatically waive the monthly premium in the event of the total disability of the person insured under this rider. There is a 6 month waiting period before benefits begin, during which time the premium must be paid. Once the waiver of premium benefit is approved, premiums paid during the 6 month waiting period will be refunded.

Premiums are payable to the earlier of the policy anniversary nearest the insured person's 65th birthday and the end of the premium paying period for the policy.

This protection continues until the policy anniversary nearest the insured person's 65th birthday. If we are waiving the monthly premium at the policy anniversary nearest that insured person's 65th birthday, we will continue to waive the premium under the terms of this rider while the insured person remains totally disabled and the policy remains in effect.

Return of Premium on Surrender or Expiry

Insured's issue age:

Plan	Issue ages	Plan	Issue ages
Live Well T10	18-55	Live Well Plus T10	18-65
Live Well T20	18-55	Live Well Plus T20	18-55
Live Well Term to age 80	18-55	Live Well Term to age 80	18-65

We may pay a benefit under this rider to the owner or the owner's estate:
a) as a result of the owner's written request for a full surrender of the insurance contract to be effective on the return of premium date identified in the request. This is called the Return of Premium on Surrender Benefit; or
b) as a result of the policy ending on the policy expiry date. This is called the Return of Premium on Expiry Benefit.

Rider Benefit Amount for Surrender

The Return of Premium on Surrender Benefit is an optional benefit. That benefit is not automatically payable on full surrender of the insurance contract. That benefit is only available on the owner's written request for a full surrender of the insurance contract, to be effective on a return of premium date, and that specifically requests this benefit. That return of premium date will also be the effective date of surrender of the insurance contract.

The amount payable under this benefit is equal to the rider benefit amount for the period from the rider date to the applicable return of premium date, multiplied by the applicable percentage from the table below minus each payment made under the Juvenile Critical Illness Insurance Rider.

(continued)

Number of policy anniversaries since the Rider Date	%
20	55%
21	60%
22	65%
23	70%
24	75%
25+	80%

Example:

The owner buys a $75,000 Live Well Plus Term to Age 80 policy with a policy issue date of September 23, 2021. The total annual premium including the Return of Premium on Surrender or Expiry is $1,238.49.

On September 13, 2043, the owner requests a surrender of their policy to be effective on September 23, 2043, a return of premium date. There have been no changes to the policy between Sept. 23, 2021 and September 23, 2043. The return of premium on surrender benefit would be $17,710.41 and the policy would be terminated.

Annual premium x Number of policy anniversaries since rider date x % = Benefit
$1,238.49 x 22 x 0.65 = $17,710.41

Return of Premium on Expiry Benefit

The Return of Premium on Expiry Benefit will become payable on the policy expiry date. The amount payable under this benefit is equal to the rider benefit amount for the period from the rider date to the policy expiry date minus each payment made by us under the Juvenile Critical Illness Insurance Rider.

Conditions for Benefit Payment

We will pay the applicable benefit under this rider if:

a) for the Return of Premium on Surrender Benefit under this rider, the owner's written request specifically requesting this benefit is received by us as shown in our records between 60 days before the next, and 30 days after the last, return of premium date;
b) the owner is living on the applicable return of premium date or policy expiry date, and have not experienced irreversible cessation of all functions of the brain; and
c) the policy and this rider are both in effect on the applicable return of premium date or the policy expiry date.

Example:

The 35-year old owner buys a $75,000 Live Well Plus Term to Age 80 policy with a September 23, 2021 policy issue date. The total annual premium including the ROP on Surrender or Expiry is $1,238.49.

On September 23, 2066, the policy ends and the owner requests their return of premium on expiry. There have been no changes to the policy between Sept. 23, 2021 and September 23, 2066. The return of premium on expiry benefit would be $55,732.05 and the policy would be terminated.

Annual premium X Number of policy anniversaries since rider date = Benefit
$1,238.49 x 45 = $55,732.05

Juvenile Critical Illness Insurance Rider
(available only on Live Well Plus policies)

Insured's issue age: 18-55

Insured child's issue age: 60 days to 17 years

Insured child must be a biological child, step-child or legally adopted child of the insured.

We may pay the rider benefit amount for each insured child first diagnosed, while this rider is in effect, with a rider covered condition. Payment of the rider benefit amount will not result in termination of the policy or this rider.

The premiums for this rider are payable up to the earlier of twenty (20) years and the date this rider is no longer in effect. The premium for this rider does not change when a child is added as an insured child after the application date for this rider.

Juvenile covered conditions

Cerebral Palsy means a non-progressive clinical disorder characterized by spasticity or incoordination of movements.

Congenital Heart Disease means any one of the following heart defects described below:

- total anomalous pulmonary venous connection;
- transposition of the great arteries;
- atresia of any heart valve;
- single ventricle;
- hypoplastic left heart syndrome;

(continued)

- truncus arteriosus;
- tetralogy of Fallot;
- Eisenmenger syndrome;
- Ebstein's anomaly; and
- double outlet left or right ventricle.

The following heart defects also satisfy the definition of Congenital Heart Disease, if surgery is performed for correction of the heart defect:

- coarctation of the aorta;
- pulmonary stenosis;
- aortic stenosis;
- discrete subvalvular aortic stenosis;
- ventricular septal defect; and
- atrial septal defect.

The diagnosis must be corroborated by cardiac imaging. The survival period for Congenital Heart Disease is 30 days. For greater certainty, non-surgical or trans-catheter techniques such as balloon valvuloplasty and percutaneous atrial septal defect closure do not qualify as surgery.

Cystic Fibrosis means a condition resulting in chronic lung disease or pancreatic insufficiency. The diagnosis must be confirmed by a positive sweat test.

Muscular Dystrophy means dystrophy of skeletal muscles confirmed by electromyography and muscle biopsy. For greater certainty, spinal muscular atrophy does not satisfy the definition of Muscular Dystrophy.

Type 1 Diabetes Mellitus means type 1 diabetes mellitus, characterized by insulin deficiency and continuous dependence on exogenous insulin for survival. The survival period for Type 1 Diabetes Mellitus is 90 days from the date of diagnosis, during which there must be evidence of dependence on insulin for survival.

Conversion Privilege

The rider benefit amount, or any part of it, may be converted for each insured child without evidence of insurability into a critical illness insurance policy of a plan type then offered by us and made available for conversion. If no other plan type is made available by us at the time of conversion, we will make available a plan that will provide coverage to the policy anniversary date nearest that insured child's 80th birthday.

Conversion is subject to the following conditions:

a) The conversion must occur while the rider is in effect and premiums are paid to the effective date of conversion.
b) The owner must submit a written request for conversion to us after that insured child's eighteenth (18th) birthday, but no later than that insured child's twenty-fifth (25th) birthday.
c) If the insured dies before that insured child's twenty-fifth (25th) birthday, the owner must submit a written request for conversion to us within sixty (60) days of the death of the insured.

Coverage for an insured child under this rider will end on the date the new policy, on that insured child, takes effect under the Conversion Privilege.

The following conditions will apply to the new policy:

1) Policy years under the new policy will be calculated from the policy date of the new policy.
2) The evidence of insurability on that insured child will become part of the new policy and can be relied upon by us to contest the new policy.
3) Each exclusion that applies to the rider on or before the effective date of conversion will become part of the new policy.
4) The benefit amount under the new policy cannot be less than the minimum amount we allow for the new plan of insurance, and it cannot exceed the lesser of $50,000 and two (2) times the rider benefit amount except when needed to meet the new plan minimum amount. The combined benefit amounts for conversions issued by us under the juvenile critical illness insurance riders on an insured child cannot exceed $50,000.
5) The premium rates applicable to the insured child under the new policy will be based on the following:
   a) The amount of insurance under the new policy;
   b) That insured child's attained age at the time of conversion;
   c) The premium rates then in effect for the new insurance policy; and
   d) That insured child's applicable insurance class used in calculating the premiums for the new policy. That insured child's applicable insurance class will be the standard smoker class unless you submit evidence of insurability, satisfactory to us, of non-smoker status. The insured child must meet our definition of a non-smoker at the time of the request.
6) Riders may be included in the new policy only with our consent and may be subject to evidence of insurability.

Underwriting

Age and amount underwriting requirements for critical illness insurance

Amount	18-40	41-45	46-50	51-55	56-60	61-65
Up to $100,000	NM	NM	NM	NM	NM	NM
$100,001 - $250,000	VT UHIV	VT BCP	VT BCP	VT BCP	PM BCP	PM BCP APS
$250,001 - $500,000	VT BCP APS	PM BCP APS	PM BCP APS	PM BCP APS	PM BCP APS	PM BCP APS
$500,001 - $1,000,000	PM BCP APS	PM BCP APS	PM BCP APS	PM BCP APS	PM BCP APS	PM BCP APS
$1,000,001 $2,000,000	PM BCP APS	PM BCP ECG APS	PM BCP ECG APS	PM BCP ECG APS	PM BCP ECG APS	PM BCP ECG APS

NM = Non Medical, PM = Paramedical, VT = Vitals, BCP = Blood Chemistry Profile (includes urine and PSA*), ECG = Resting Electrocardiogram, APS = attending physician's statement

* Prostate Specific Antigen (PSA) is required for Critical Illness applications for males over the age of 50, when a BCP is part of the requirements.

Validity of Requirements

- Paramedical (PM), Medical Exam (ME), Vitals (VT), Laboratory Tests (Blood Chemistry Profiles (BCP), Urine and Urine HIV specimens (UHIV)) and Motor Vehicle Report (MVR) are valid for a maximum of 6 months from the date they were completed.
- Resting electrocardiogram (ECG), Treadmill Stress Electrocardiogram (TST) and Inspection Report (IR) are valid for a maximum of 12 months from the date they were completed.
- For substandard cases, we reserve the right to request any requirement completed earlier than the timelines described above.

Total amount applied for

- Underwriting requirements are for the total amount applied for with Foresters in the past 6 months. Requirements previously completed should not be repeated when still valid as described under Validity of Requirements above.
- If applying for both Live Well Plus and a life product, please order the more stringent requirements of the two; do not add the face amounts.
- For concurrent applications with other carriers where the age and amount requirements exceed the chart requirements above, we reserve the right to request any additional requirements the other carrier may have.

Current dating

All policies will be current dated.

Backdating

Specific dating requests must be provided at the time of application or at least prior to approval of the policy. Subject to Underwriting approval, Foresters may backdate a policy up to a maximum of 30 days before the application in order to save a younger age. Foresters will current date coverage unless Foresters is specifically requested to save age.

Appendix A: Covered Conditions

Coverage is provided for the conditions, disorders, illnesses and surgeries described below:

Aortic Surgery is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Aplastic Anemia is defined as a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and

thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a specialist.

Bacterial Meningitis is defined as a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a specialist.

For purposes of this policy, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour is defined as a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits. The diagnosis of Benign Brain Tumour must be made by a specialist.

For purposes of this policy, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

No benefit will be payable under this condition during the moratorium period if the Insured has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any benign brain tumour (covered or not covered under the policy), regardless of when the diagnosis is made; or
- A diagnosis of any benign brain tumour (covered or not covered under this policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any benign brain tumour or its treatment.

Blindness is defined as a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- The corrected visual acuity being 20/200 or less in both eyes; or,
- The field of vision being less than 20 degrees in both eyes.

The diagnosis of Blindness must be made by a specialist.

Cancer is defined as the definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a specialist and must be confirmed by a pathology report.

For purposes of this policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions: No benefit will be payable under this condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;
- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than medication to counteract the effects from hormonal oversecretion by the tumour; or
- Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

No benefit will be payable under this condition during the moratorium period if the Insured has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under this policy), regardless of when the diagnosis is made; or
- A diagnosis of any cancer (covered or not covered under this policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis, must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or, any critical illness caused by any cancer or its treatment.

Coma is defined as a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of Coma must be made by a specialist.

Exclusion: No benefit will be payable under this condition for:

- A medically induced coma;
- A coma which results directly from alcohol or drug use; or,
- A diagnosis of brain death.

Coronary Artery Bypass Surgery is defined as the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Deafness is defined as a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of Deafness must be made by a specialist.

Dementia, including Alzheimer's Disease is defined as a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The diagnosis of Dementia must be made by a specialist.

Exclusions: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

Heart Attack (acute myocardial infarction) is defined as a definite diagnosis of death of heart muscle due to obstruction of blood flow, that results in:

- A rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

  - Heart attack symptoms;
  - New electrocardiographic (ECG) changes consistent with a heart attack;
  - Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

The diagnosis of heart attack (acute myocardial infarction) must be made by a specialist.

Exclusions: No benefit will be payable under this condition for:

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair is defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Kidney Failure is defined as a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a specialist.

Loss of Independent Existence is defined as a definite diagnosis of the total inability, due to disease or injury, to perform independently:

- with or without the aid of assistive devices at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery; and
- the diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

- Bathing: washing oneself in a bathtub, shower or by sponge bath;
- Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- Toileting: getting on and off the toilet and maintaining personal hygiene;
- Bladder and bowel continence: managing your bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring: moving in and out of a bed, chair or wheelchair;
- Feeding: consuming food or drink that already have been prepared and made available

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs is defined as a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a specialist.

Loss of Speech is defined as a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List is defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Major Organ Transplant is defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist.

Motor Neuron Disease is defined as a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of Motor Neuron disease must be made by a specialist.

Multiple Sclerosis is defined as a definite diagnosis of at least one of the following occurring after the later of the effective date, or the date of the last reinstatement of this policy:

- Two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or

- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of Multiple Sclerosis must be made by a specialist.

For purposes of this policy, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome;
- Neuromyelitis optica spectrum disorders; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion - No benefit will be payable under this condition if, within the first year following the later of the effective date of this policy or the date of the last reinstatement of the policy, the Insured has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the diagnosis is made; or
- A diagnosis of multiple sclerosis (covered or not covered under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the effective date of this policy, or the effective date of last reinstatement of this policy.

Payment under this condition requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a specialist.

Exclusions: No benefit will be payable under this condition if:

- The Insured has elected not to take any available licensed vaccine offering protection against HIV;
- A licensed cure for HIV infection has become available prior to the accidental injury; or,
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis is defined as a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

1-Year Exclusions: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if within the first year following the later of, the effective date of this policy or the date of last reinstatement of this policy, the Insured has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or

- A diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns is defined as a definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits) is defined as a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism, with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination, persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of stroke must be made by a specialist.

For purposes of this policy, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision , measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for:

- Transient Ischaemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischaemic disorders of the vestibular system;
- Death of tissue of the optic nerve or retina without total loss of vision of that eye; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.

Appendix B: Non-Life-Threatening Illness Covered Conditions

Chronic Lymphocytic Leukemia (CLL) Rai Stage 0 is defined as a definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL). For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Conkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975. The condition must be diagnosed by a specialist.

No benefit will be payable for Monoclonal Lymphocytosis of Undetermined Significance (MLUS).

Coronary angioplasty is defined as the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist.

Ductal carcinoma in situ of the breast is defined as a definite diagnosis of ductal carcinoma in situ of the breast. The condition must be diagnosed by a specialist and confirmed by biopsy.

Papillary or Follicular Thyroid Cancer Stage T1 is defined as a definite diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis. The condition must be diagnosed by a specialist and confirmed by a biopsy.

Stage A (T1a or T1b) Prostate Cancer is defined as a definite diagnosis of stage A (T1a or T1b) prostate cancer. The condition must be diagnosed by a specialist.

Stage 1 Malignant Melanoma is defined as a definite diagnosis of Stage 1A or 1B malignant melanoma that is 1.0 mm or less in depth and non-ulcerated. The condition must be diagnosed by a specialist.

No benefit will be payable for malignant melanoma in situ.

Gastrointestinal Stromal Tumours is defined as tumours classified as AJCC Stage 1. The condition must be diagnosed by a specialist.

Grade 1 Neuroendocrine Tumours (Carcinoid) is defined as tumours confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to counteract the effects from hormonal over secretion by the tumour. The condition must be diagnosed by a specialist.

For purposes of the non-life-threatening illness covered conditions, the terms:

a) Tis, Ta, T1a, T1b, T1, Grade 1 and AJCC Stage 1 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010; and

b) Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

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[1] Underwritten by Foresters Life Insurance Company.

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