The Independent Order of Foresters ("Foresters")
A Fraternal Benefit Society.
789 Don Mills Road, Toronto, ON, Canada M3C 1T9 F. 877 329 4631
U.S. Mailing Address: P.O. Box 179 Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Arrhythmia/Atrial Fibrillation/Irregular Heartbeat Questionnaire

Proposed Insured

First name ______________________ Middle name ______________ Last name ______________________

Date of Birth ____________________ Reference/certificate number (if available): ______________________
(mmm/dd/yyyy)

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. When was this condition first diagnosed? Please attach a copy of any medical reports, if available. ______________________
Date (mmm/dd/yyyy)

2. Is the arrhythmia/atrial fibrillation/irregular heartbeat:
O chronic (permanent) O premature supraventricular atrial beats (PAC's) O bigeminy or trigeminy
O proxysmal (intermittent) O premature ventricular beats (PVC's) O ventricular tachycardia
O multifocal

3. Are there any symptom(s) with the arrhythmia/atrial fibrillation/irregular heartbeat?
O Black-out
O Dizziness (light-headedness)/faint feeling
O Palpitations
O Chest discomfort

4. Have any of the following tests been done for this condition? If so, please give date and results:
O ECG ______________________ ______________ Date (mmm/dd/yyyy)
O Stress test ______________________ ______________ Date (mmm/dd/yyyy)
O Echocardiogram ______________________ ______________ Date (mmm/dd/yyyy)
O Holter monitor ______________________ ______________ Date (mmm/dd/yyyy)

5. Do you currently take medication(s) for this condition? Yes O No O
If "Yes", please provide details:

Name of medication(s)	Dose	Frequency

6. Other than already stated, have you taken other medication(s) or been treated with surgery in the past for this condition? Yes O No O
If "Yes", please provide details:

Name of medication(s) or treatment(s)	Dose	Frequency	Date last taken
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)

7. The cause of the arrhythmia/atrial fibrillation/irregular heartbeat is due to:
O coronary heart disease O alcohol O thyroid disease O unknown
O mitral valve disease O cardiomyopathy O anxiety
O other, give details ____

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8. Please provide details regarding the physician(s) and/or medical practitioner(s) you see, have seen, or have been referred to in relation to this condition:

Name of physician, hospital or clinic	Address	Frequency	Dates
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)

9. Have you ever taken time off work or have your working duties been affected or restricted in any way due to this condition? Yes O No O
If "Yes", please provide details including dates and durations. ____

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10. Please provide any additional information that you feel is important in relation to this condition:___________________________________

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I declare that I have read this questionnaire and represent that the information provided, as shown in this questionnaire, is true, and is a complete disclosure of all information requested in this questionnaire, to the best of my knowledge and belief. I understand and agree that this questionnaire is part of and subject to the Application. I also understand and agree that the information provided in this questionnaire will be relied upon as evidence of insurability that will influence the assessment and acceptance of the application by Foresters.

X ___________________________________
Signature of proposed insured (if the proposed insured is not a juvenile)

X ___________________________________
Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at ___________________________________
(City, State)

Signed on ___________________________________
Date (mmm/dd/yyyy)