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

Foresters Financial

Chest Pain 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. Please list medical and physical problems diagnosed, treated, tested positive for or for which you have been given medical advice by a member of the medical profession. (e.g. angina, costochondritis, esophageal reflux, muscle strain, myocardial infarction, palpitations, stress, etc.). Attach a copy of any medical report(s) if available. _____
_____
_____

2. When was this condition diagnosed? _____
Date (mmm/dd/yyyy)

3. Have you consulted with a member of the medical profession regarding a recurrence of your condition? Yes O No O
If "Yes", please provide details including frequency, duration, and the approximate date of the last episode: _____
_____

4. Has a member of the medical profession advised you that your condition is associated with exercise, exertion, excitement, food, infection, strain, other? Yes O No O
If "Yes", please provide details: _____
_____

5. Please provide details of any test(s) or investigation(s) that you have undergone in relation to this condition, (e.g. blood tests, chest x-rays, coronary angiogram, echocardiograph, electrocardiograph, endoscopy, exercise stress test etc.).

Name of test or investigation	Location	Date	Results
		(mmm/dd/yyyy)	
		(mmm/dd/yyyy)	
		(mmm/dd/yyyy)	

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

Name of medication	Dose	Frequency

7. Other than already stated, have you taken other medication in the past for this condition? Yes O No O
If "Yes", please provide details:

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

8. Other than already stated, have you ever been admitted to a hospital or had out-patient treatment for this condition? Yes O No O
If "Yes", please provide details:

Details of treatment	Name of physician, hospital or clinic	Dates
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)

9. 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	Date of last consult
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)

10. Has any further treatment(s) or follow-up been discussed with or recommended by a physician or medical practitioner, in relation to this condition? Yes O No O
If "Yes", please provide details: _____

_____

11. Have you been advised by a member of the medical profession to limit any leisure activities, take time off work or restrict your working duties in any way due to this condition? Yes O No O
If "Yes", please provide details including dates and durations:_____

_____

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

_____

_____

_____

I declare that I have read this Chest Pain 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)