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

Diabetes Questionnaire

Proposed Insured

First name _____ Middle name _____ Last name _____

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

Child's Name _____

Note – "You" and "your" mean the proposed insured, if no child is indicated or the child if a child is indicated. "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, in relation to this condition. (e.g. Type I or Type II Diabetes Mellitus, Gestational Diabetes, Impaired Glucose Tolerance or Impaired Fasting Glucose etc.). Attach a copy of any medical reports if available.

   _____

   _____

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

3. Do you test your own blood sugar at home? Yes O No O
   If "Yes", please provide details for the last 3 months:

Frequency of testing	Lowest result	Highest result	Average result

4. Have you had a glycosylated haemoglobin test (HbA1c)? Yes O No O
   If "Yes", please provide details including the approximate date and result of your most recent test: _____

   _____

5. Please provide details of the medication(s) that you take in relation to this condition (please also include related medication(s) such as those used to lower blood pressure and/or cholesterol):

Name of medication	Dose	Frequency

6. Have you ever been admitted to a hospital or required emergency care in relation to this condition? Yes O No O
   If "Yes", please provide details:

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

7. Related to this condition, have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:
   i) Eye problems? Yes O No O
   ii) Heart problems? Yes O No O
   iii) High blood pressure? Yes O No O
   iv) Kidney problems (including protein in your urine)? Yes O No O
   v) Sensory problems (such as burning in your feet)? Yes O No O
   vi) Any other complication (i.e. diabetic coma)? Yes O No O

   If you answered "Yes" to any of the above questions, please provide details: _____

   _____

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

9. Other than for the purpose of regular checks, 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: _____

   _____

10. 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. _____

    _____

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

    _____

    _____

    _____

I declare that I have read this Diabetes 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)