

The Independent Order of Foresters ("Foresters")



A Fraternal Benefit Society.

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Drug and Substance Usage Questionnaire

Proposed Insured	
First name _____	Middle name _____ Last name _____
Date of Birth _____ (mmm/dd/yyyy)	Reference/certificate number (if available): _____

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

1. Please indicate which of the following substances you have ever tried or used:

- i) Alcohol (if “Yes”, a separate Alcohol Usage Questionnaire may be required) _____ Yes No
- ii) Amphetamines (speed, uppers, dexies, crystal meth, ice etc.) _____ Yes No
- iii) Anabolic steroids (roids, gear, juice etc.) _____ Yes No
- iv) Barbiturates (amytal, Phenobarbital etc.) _____ Yes No
- v) Cannabis (marijuana, dope, hooch, grass, pot, hashish, THC etc.) _____ Yes No
- vi) Cocaine (coke, blow, snow, crack etc.) _____ Yes No
- vii) Ecstasy (meth amphetamine, MDMA, ecky, E’s etc.) _____ Yes No
- viii) Opiates (codeine, heroin, methadone, morphine, pethidine, smack etc.) _____ Yes No
- ix) Psychedelics (magic mushrooms, LSD, acid etc.) _____ Yes No
- x) Solvents (glue, aerosol, thinners, nitrous oxide, petrol etc.) _____ Yes No
- xi) Others: _____ Yes No

If you answered “Yes” to any of the above questions, please provide details regarding your usage pattern:

Name of Substance	Date first used	Date ceased	Frequency of use
	(mmm/dd/yyyy)	(mmm/dd/yyyy)	
	(mmm/dd/yyyy)	(mmm/dd/yyyy)	
	(mmm/dd/yyyy)	(mmm/dd/yyyy)	
	(mmm/dd/yyyy)	(mmm/dd/yyyy)	

2. Have you ever injected or used intravenously drugs that were not prescribed by a licensed physician? Yes No

If “Yes”, please provide details including dates: _____

3. Have you ever tested positive for Hepatitis B or C? Yes No

If “Yes”, please provide details including dates and results: _____

4. Have you ever sought medical advice or been referred to drug counseling? Yes No

If “Yes” please provide details:

Name of Physician, hospital or clinic	Address	Date of last consult
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)

5. Have you ever been hospitalized or treated for a drug overdose? Yes No

Name of Physician, hospital or clinic	Address	Date
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)

6. Have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any medical condition or impairment related to your drug use, e.g. hepatitis, HIV, mental health disorder etc.? Yes No
If "Yes", please provide details including dates and results: _____

7. Have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous or a similar association? Yes No
If "Yes", please answer the following questions:
When? _____
Are you presently active? _____
How often do you attend meetings? _____
How many meetings did you attend in the last six months? _____
Have you had any lapses? Yes No
If "Yes", please state relevant dates: _____

8. Have you ever pled guilty to, or been convicted of, any alcohol or drug related offence or been required to attend an alcohol or drug awareness program ordered by the court? Yes No
If "Yes", please provide details including dates for each occurrence: _____

9. Have you ever taken time off work or have your working duties been affected or restricted in any way due to your alcohol and/or drug use? Yes No
If "Yes", please provide details including dates and durations. _____

10. Please provide any additional information that you feel is important in relation to your alcohol or drug use: _____

I declare that I have read this Drug and Substance Usage 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)