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

Kidney and Urinary Disorders Questionnaire

Proposed Insured

First name _____ Middle name _____ Last name _____

Date of Birth _____ Reference number/certificate (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, and attach a copy of any medical reports if available. _____
_____

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

3. Have you had an intravenous pyelogram (IVP), cystoscopy or other test(s) or investigation(s) in relation to this condition? Yes O No O
If "Yes", please provide details of the results including date(s) of the test(s) and the investigation(s): _____
_____

4. Have you had an operation for this condition or is an operation being considered? Yes O No O If "Yes",
   a) Please provide date(s) and full details including names of the hospital and consultant, physician/surgeon. _____
   _____
   b) Have any medical and physical problems been diagnosed, treated, tested positive for or for which you have been given medical advice by a member of the medical profession, related to your condition, following surgery? Yes O No O If "Yes", please provide details. _____
   _____

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

Name of medication	Dose	Frequency

6. Other than already stated, have you taken other medication(s) or had other treatment 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)

7. 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)

8. 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. _____

_____

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

_____

_____

_____

I declare that I have read this Kidney and Urinary Disorders 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 _____ **X** _____

Signature of proposed insured (if the proposed insured is not a juvenile) Signature of parent/legal guardian (if the proposed insured is a juvenile)

Signed at _____ Signed on _____

(City, State) Date (mmm/dd/yyyy)