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

Mental Health 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 indicate which of the mental health condition(s) you have/had diagnosed, treated, tested positive for or for which you have been given medical advice by a member of the medical profession:
   a) Anxiety including generalized anxiety, panic or phobia disorder — Yes O No O
   b) Eating disorder including anorexia nervosa or bulimia — Yes O No O
   c) Depression including major depression or dysthymia — Yes O No O
   d) Bipolar disorder or manic depressive illness — Yes O No O
   e) Alcohol or other substance abuse or addiction — Yes O No O
   f) Post-traumatic stress — Yes O No O
   g) Schizophrenia or any other psychotic disorder — Yes O No O
   h) Stress, sleeplessness, chronic tiredness — Yes O No O
   i) Other (please describe): — Yes O No O
   _____

2. Please provide details for the conditions indicated above.:

Details	Date from	Date to
	(mmm/dd/yyyy)	(mmm/dd/yyyy)
	(mmm/dd/yyyy)	(mmm/dd/yyyy)
	(mmm/dd/yyyy)	(mmm/dd/yyyy)
	(mmm/dd/yyyy)	(mmm/dd/yyyy)

3. Has any reason for your condition been identified by a member of the medical profession? Yes O No O
   If "Yes", please provide details: _____
   _____

4. When was the condition first diagnosed? _____
   Date (mmm/dd/yyyy)

5. Have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any recurrence of this condition(s)? Yes O No O
   If "Yes", please provide details:

Date from	Date to
(mmm/dd/yyyy)	(mmm/dd/yyyy)
(mmm/dd/yyyy)	(mmm/dd/yyyy)
(mmm/dd/yyyy)	(mmm/dd/yyyy)

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

Name of medication	Dose	Frequency

7. Other than already stated above, have you taken other medication(s) 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)

8. Have you ever had any other treatment(s) for this condition e.g. counseling, cognitive behavioral therapy, electroconvulsive treatment etc.? Yes O No O
If "Yes", please provide details:

Nature of treatment	Location	Date
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)

9. Have you ever been admitted to a hospital or clinic for this condition? Yes O No O
If "Yes", please provide details:

Name of physician, hospital or clinic	Address	Date(s)
		(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. 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	Dates
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)
		(mmm/dd/yyyy)

12. 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. _____
_____

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

I declare that I have read this Mental Health 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)