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

Respiratory Disorders 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 the 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. asthma, bronchitis, COPD, emphysema, shortness of breath etc.) and attach any medical reports if available. ____
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2. When was the condition diagnosed? _________________________________
Date (mmm/dd/yyyy)

3. Has a member of a medical profession advised you that your condition is precipitated by seasonal changes, exercise, respiratory infections etc.? Yes O No O
If "Yes", please provide details: ____
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4. Do you currently take medication(s) for this condition? Yes O No O
If "Yes", please provide details:

Name of medication	Dose	Frequency

5. Other than already stated, have you taken other medication(s) in the past for this condition or been treated with oral steroids or oxygen therapy? 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)

6. Have you ever had any test(s) or investigation(s) carried out in connection to this condition (e.g. pulmonary function tests/spirometry, peak flow, chest x-ray etc.)? Yes O No O
If "Yes", please provide details and attach copies of any medical reports if available:

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

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7. Have you ever been treated in Emergency, admitted to hospital or had out-patient follow-up for this condition? Yes O No O
If "Yes", please provide details:

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

8. 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: ______________________________

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

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. ______________________________

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

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I declare that I have read this Respiratory 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 ______________________________
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)