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

Epilepsy and Seizure Disorder 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 state the precise diagnosis or nature of the condition for which you have been diagnosed, treated, tested positive for or for which you have been given medical advice by a member of the medical profession. (e.g. absence seizures (petit mal), atonic seizures (drop attacks), myoclonic seizures, tonic clonic seizures (grand mal), simple partial seizures, complex seizures (psychomotor)). Attach a copy of any medical reports if available. _____

   _____

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

3. How often do you typically experience a seizure? _____/week _____/month _____/year

4. Has a member of the medical profession advised you of anything that may precipitate your symptoms? Yes O No O
   If "Yes", please provide details: _____

   _____

5. When was your last seizure? _____
   Date (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(s)	Dose	Frequency

7. Other than already stated, have you taken other medication(s) or had other treatment(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 test(s) or investigation(s) (e.g. electroencephalogram (EEG), CT scan, MRI scan, other etc.), in relation to this condition? Yes O No O
   If "Yes", please provide details:

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

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

Name of physician, hospital or clinic	Address	Frequency	Dates
			(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	Date of last consult
		(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. Are you permitted to drive a motor vehicle? Yes O No O
14. Please provide any additional information that you feel is important in relation to this condition:_____

_____

_____

_____

I declare that I have read this Epilepsy and Seizure Disorder 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)