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

Sleep Apnea/Sleep Disorder 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. Have you ever been diagnosed with a sleep disorder? Yes O No O

   If "Yes", identify: O Sleep apnea O Narcolepsy O Insomnia O Other (specify) _____

   Date of onset: _____

   Symptoms at the time of diagnosis: _____

   _____

2. Has a member of the medical profession advised you that you have depression or anxiety as a result of your disorder? *(complete a Mental Health Questionnaire if "Yes")* Yes O No O

3. Have you had any sleep studies, test(s) or other investigation(s) for a diagnosed disorder or have they been ordered due to a suspected sleep disorder? Yes O No O
   If "Yes", please provide details:

Test/Investigation	Date	Result
	(mmm/dd/yyyy)	
	(mmm/dd/yyyy)	
	(mmm/dd/yyyy)	

4. Do you receive or have you received any treatment or have any treatments been recommended for a sleep disorder, including medication(s) and/or devices?
   Yes O No O
   If "Yes", please provide details:

Treatment, device or medication	Date prescribed	Prescribed dosage or frequency of use	Date last used
	(mmm/dd/yyyy)		(mmm/dd/yyyy)
	(mmm/dd/yyyy)		(mmm/dd/yyyy)
	(mmm/dd/yyyy)		(mmm/dd/yyyy)

   Has treatment O improved O eliminated O not changed your symptoms? O unknown

5. 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)

6. 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: _____

_____

_____

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

_____

_____

_____

I declare that I have read this Sleep Apnea/Sleep 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)