Documents Package Prepared for: **Foresters ezbiz – NMO**

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Document Name	Description	Expiration Date
105127_US	Diabetes Questionnaire	12/31/2199
105137_US	Mental Health Questionnaire	12/31/2199
105119_US	Arthritis Questionnaire	12/31/2199
105141_US	Respiratory Disorders Questionnaire	12/31/2199
105134_US	High Blood Pressure Questionnaire	12/31/2199
105122_US	Back and Neck Questionnaire	12/31/2199
105144_US	Tobacco Questionnaire	12/31/2199

The Independent Order of Foresters ("Foresters") - A Fraternal Benefit Society.
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The Independent Order of Foresters ("Foresters")

Diabetes Questionnaire

Proposed Insured

First name _____ Middle name _____ Last name _____

Date of Birth _____ (mmm/dd/yyyy) Reference/certificate number (if available):_____

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, in relation to this condition. (e.g. Type I or Type II Diabetes Mellitus, Gestational Diabetes, Impaired Glucose Tolerance or Impaired Fasting Glucose etc.). Attach a copy of any medical reports if available.

   _____

   _____

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

3. Do you test your own blood sugar at home? Yes O No O
   If "Yes", please provide details for the last 3 months:

Frequency of testing	Lowest result	Highest result	Average result

4. Have you had a glycosylated haemoglobin test (HbA1c)? Yes O No O
   If "Yes", please provide details including the approximate date and result of your most recent test: _____

   _____

5. Please provide details of the medication(s) that you take in relation to this condition (please also include related medication(s) such as those used to lower blood pressure and/or cholesterol):

Name of medication	Dose	Frequency

6. Have you ever been admitted to a hospital or required emergency care in relation to this condition? Yes O No O
   If "Yes", please provide details:

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

7. Related to this condition, have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:

i)	Eye problems?	Yes O No O
ii)	Heart problems?	Yes O No O
iii)	High blood pressure?	Yes O No O
iv)	Kidney problems (including protein in your urine)?	Yes O No O
v)	Sensory problems (such as burning in your feet)?	Yes O No O
vi)	Any other complication (i.e. diabetic coma)?	Yes O No O

If you answered "Yes" to any of the above questions, please provide details: _____

_____

8. 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)

9. Other than for the purpose of regular checks, 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: _____

_____

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. _____

_____

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

_____

_____

_____

I declare that I have read this Diabetes 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)

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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)

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The Independent Order of Foresters ("Foresters")

Arthritis Questionnaire

Proposed Insured

First name _____ Middle name _____ Last name _____

Date of Birth _____ (mmm/dd/yyyy) Reference number (if available)/certificate number:_____

Note – "You" and "your" mean the proposed insured. "Application" means the Application for Individual Life Insurance on the proposed insured.

1. What type of arthritis do you have? O Rheumatoid O Osteoarthritis O Other: _____
2. Severity: O Mild O Moderate O Severe
3. When was this first diagnosed? _____ Date (mmm/dd/yyyy)
4. 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, in relation to this condition. Include joints affected, type of deformity, and limitation of movement, as applicable.: _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____
5. Do you use any aids, (e.g. canes, walkers, wheelchair)?_____
6. Have you had an operation for arthritis or is an operation being considered? Yes O No O
7. Do you currently take any medication for this condition? Yes O No O
   If "Yes", please provide details:

Name of medication	Dose	Frequency

8. 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 or treatment	Dose	Frequency	Date last taken
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)

9. Have you had any test(s) or investigation(s) for this condition? (e.g. X-rays, CT scans, MRI?) Yes O No O
If "Yes", please provide details:

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

10. Please provide details regarding the physician(s) and/or medical practitioner(s) you 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)

11. 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. _____
_____

12. 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: _____
_____

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

I declare that I have read this Arthritis 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)

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Respiratory Disorders Questionnaire

Proposed Insured

First name _____ Middle name _____ Last name _____

Date of Birth _____ (mmm/dd/yyyy) Reference/certificate number (if available):_____

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. _____

   _____

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: _____

   _____

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)	

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: _____

_____

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. _____

_____

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

_____

_____

_____

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)

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High Blood Pressure 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. When were you first diagnosed with high blood pressure? _____
Date (mmm/dd/yyyy)

2. Why was your blood pressure measured at that particular time? E.g. routine examination, due to symptoms etc.? _____

_____

3. Do you know what your blood pressure readings were at diagnosis? Yes O No O
If "Yes", please provide details: _____

4. Have you had an EKG, X-ray, blood lipid, urine abnormalities (e.g. protein, blood, etc.) or other test investigation(s) in relation to this condition? Yes O No O
If "Yes", please provide details of the result, including date(s) of the test(s) and investigation(s): _____

_____

_____

_____

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) 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 doctor(s) and/or medical practitioner(s) you see, have seen or have been referred to in relation to this condition:

Name of doctor, hospital or clinic	Address	Frequency	Date of last consult
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)

8. Do you smoke cigarettes, cigars or a pipe? Yes O No O
   If "Yes", please specify type and how many a day?: _____

9. 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. _____
   _____

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

I declare that I have read this High Blood Pressure 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)

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Back & Neck Questionnaire

Proposed Insured

First name _____ Middle name _____ Last name _____

Date of Birth _____ Reference number/certificate (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. What type of back or neck disorder do you have, as diagnosed, treated, tested positive for or for which you have been given medical advice by a member of the medical profession? Select all that apply.

   O Simple back strain O Degenerative disk disease O Herniated disk O Lumbago

   O Sciatica O Spondylosis O Spondyloarthropathy O Whiplash

   O Other _____

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

3. Was your disorder caused by an accident, or recreational or sporting injury? _____

4. Please advise which part of your back is/was affected (e.g. cervical spine (neck), thoracic spine (upper middle) or lumbar spine (lower)) and describe your symptoms including details of any radiation down the arms or legs: _____

   _____

5. Have your daily activities been affected or restricted in any way due to this condition? Yes O No O
   If "Yes", please provide details: _____

   _____

   _____

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. Please provide details of any other treatment that you have had for this condition, (e.g. surgery, treatment by a physiotherapist, chiropractor, osteopath, massage therapist, acupuncturist etc.):

Type of treatment.	Name of practitioner or clinic.	Address.	Date of last consult.
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)
			(mmm/dd/yyyy)

9. Have you ever had any test(s) or investigation(s) carried out in relation to this condition, (e.g. x-ray, MRI, CT scan or nerve conduction studies)? Yes O No O
If "Yes", please provide details including dates, procedures, locations and results:

Name of test or investigation.	Address.	Date.	Result.
		(mmm/dd/yyyy)	
		(mmm/dd/yyyy)	
		(mmm/dd/yyyy)	

10. Have you ever been admitted to a hospital for this condition? Yes O No O
If "Yes", please provide details including dates, procedures, locations and results: _____

_____

11. 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: _____

_____

12. 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)

13. Have you ever taken time off work or have your working duties ever been affected or restricted in any way (e.g. restricted ability to drive, lift, carry objects, bend or sit for prolonged periods) in relation to this condition? Yes O No O
If "Yes", please provide details including dates and durations:_____

_____

14. Have you been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for anxiety or depression in relation to this condition? Yes O No O
If "Yes", please provide details including dates and durations:_____

_____

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

_____

_____

I declare that I have read this Back & Neck 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)

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Tobacco 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. Do you use tobacco? Yes O No O
   (Including cigarettes, chewing tobacco, cigars, nicotine patch, nicotine gum, snuff, marijuana)
   If "Yes", what type(s) and how often? _____
   _____

2. Have you ever used tobacco? Yes O No O
   If "Yes", please give date tobacco was last used:_____
   _____

I declare that I have read this Tobacco 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)