The Independent Order of Foresters ("Foresters")
A Fraternal Benefit Society.
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U.S. Mailing Address: P.O. Box 179 Buffalo, NY 14201-0179 T. 800 828 1540 foresters.com

Foresters Financial

Medical Examination Report - Part 1

For each "Yes" answer to a question in Part 1 of this report, providing details in the Additional Information section may be required. If additional space is needed, attach additional pages, signed by the proposed insured. For purposes of Part 1 of this report, "you" and "your" mean the proposed insured, "diagnosed", "tested", "advised", "treated", "counseling" and "treatment" mean by a licensed physician or medical practitioner. "Application" means the Application for Individual Life Insurance on the proposed insured.

Proposed Insured

First name	Middle name	Last name	Date of birth (mmm/dd/yyyy)

Medical Questions

1. a) Date you last consulted a physician: _____ Physician Name: _____
   Address: _____ Phone #: _____
   b) Reason(s) you last consulted a physician: _____
   c) Were you advised that results of that consultation were outside normal ranges? O Yes O No

2. Primary Physician Name (if different from question 1): _____
   Address: _____ Phone #: _____

3. Are you currently taking prescription medication or under treatment? O Yes O No

4. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? O Yes O No

5. Within the past 2 years, have you:
   a) Had or been advised to have a test (other than for HIV) such as an EKG, CT scan, bone scan, MRI scan, colonoscopy, echocardiogram, angiogram, biopsy, or endoscopy? O Yes O No
   b) Been advised to have a check up, consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic test (other than for HIV) that has not yet been started or completed, or the results of which are not yet known? O Yes O No

6. Do you currently:
   a) Reside in a nursing home or skilled nursing facility or psychiatric facility, or are you receiving or been advised to receive, skilled nursing care, hospice care, or home healthcare for a terminal condition that is expected to result in death within the next 12 months or for a chronic condition? O Yes O No
   b) Require the use of a wheelchair due to a chronic illness or disease? O Yes O No
   c) Require assistance with any of the following activities of daily living: taking medications, bathing, dressing, eating, or toileting? O Yes O No

7. Within the past 3 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for sleep apnea, seizures or epilepsy? O Yes O No

8. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for:
   a) Diabetes, high blood pressure, a disease or disorder of the blood or lymphatic system, coronary artery disease, heart murmur, chest pain, irregular heartbeat, aneurysm, stroke, transient ischemic attack, congestive heart failure (CHF), a disease or disorder of the arteries or valves, peripheral vascular or arterial disease (PVD or PAD), or had a heart attack, heart surgery, heart procedure or circulatory surgery? O Yes O No
   b) Cancer (excluding skin cancer that is basal cell carcinoma), tumor, gastrointestinal bleeding, unexplained weight loss, or a disease or disorder of the pancreas or endocrine system? O Yes O No
   c) Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, or a disease or disorder of the respiratory system or do you currently require the use of oxygen equipment? O Yes O No
   d) Dementia, Alzheimer's disease, paralysis, multiple sclerosis, Parkinson's disease, Lou Gehrig's disease (ALS), muscular dystrophy, fibromyalgia, or a disease or disorder of the brain or nervous system? O Yes O No
   e) Anxiety, depression, manic depression, bi-polar disorder, schizophrenia, or a mental health disorder? O Yes O No
   f) Blood in the urine, hepatitis, Crohn's disease, Systemic Lupus, cirrhosis, or a disease or disorder of the liver, prostate, bladder, kidney, genito-urinary organs, connective tissue or the digestive or immune system (other than HIV)? O Yes O No
   g) High cholesterol? O Yes O No

9. Have you ever used tobacco, in any form, or another nicotine product? O Yes O No
   If "Yes", specify: Type used: _____ Date last used: _____ If currently smoking, how many pack(s) per day? _____

10. Do you currently drink alcohol? If "Yes", specify: How many times per week? _____ How many drinks per occasion? _____	O Yes O No
11. Within the past 5 years, have you consulted a physician other than identified above, or a medical practitioner, or been treated, tested or monitored in a clinic, hospital or emergency room?	O Yes O No
12. Do you have, alive or deceased, a parent or sibling diagnosed with or treated for, prior to age 65, diabetes, heart attack, heart disease, stroke, cancer, polycystic kidney disease, Huntington's Chorea, or Alzheimer's?	O Yes O No

Details to "Yes"	Age, if living	Age, at death	Details of condition / Cause of death
Father			
Mother			
Sibling(s)			

Disability Income / Waiver Rider Questions (Complete only if applying for disability income or waiver coverage.)

13. a) Hours worked per week (past 6 months):_____ b) # of weeks worked (past 12 months): _____	
14. Within the past 180 days, have you been unable to work at your regular job for more than 20 consecutive days or are you currently not actively at work due to an injury or sickness?	O Yes O No
15. Within the past 10 years, have you been diagnosed with, or received treatment or medication, tested positive or been given medical advice for arthritis or for a disease or disorder of the back, neck or musculoskeletal system?	O Yes O No

Additional Information (Explain all "Yes" answers where applicable.)

Include Question #, diagnosis, date first diagnosed, treatment, medications, medical facilities and physicians' name, addresses, phone #s.

I declare that I have read Part 1 of this report and represent that the information provided, as shown in this report, is true, and is a complete disclosure of all information requested in this report, to the best of my knowledge and belief. I understand and agree that this report is part of and subject to the Application. I also understand and agree that the information provided in this report will be relied upon as evidence of insurability that will influence the assessment and acceptance of the Application by Foresters.

Signature of proposed insured or parent/legal guardian, if the proposed insured is a juvenile: **X** _____

Signed at (City, State): _____ Signed on (mmm/dd/yyyy):_____

I, as the medical examiner, by signing below, declare that I (a) reviewed photo identification to confirm the age and identity of the proposed insured, (b) completed, and accurately recorded the information as shown in, Part 2 of this report and (c) witnessed the signature of the proposed insured or parent/legal guardian.

Medical Examiner's Name (please print): _____

Signature of Medical Examiner: **X** _____ Signed on (mmm/dd/yyyy):_____

Medical Examination Report - Part 2 This examination should be made in private.

For purposes of Part 2 of this report, "you" means the person conducting the examination.

16. a)

Height	Weight	Males only:		
		Chest (full inspiration).	Chest (force expiration).	Abdomen, at umbilicus.
ft. in.	lbs.	in.	in.	in.

b) Did you weigh the proposed insured? O Yes O No

c) Did you measure the proposed insured? O Yes O No

d) Is appearance unhealthy or older than age, based on date of birth shown in this report? O Yes O No

17. Blood pressure (record ALL readings)

Systolic			
Diastolic – 4th phase.			
– 5th phase.			

18. Pulse

	At Rest	After Exercise	3 minutes later
Rate			
Irregularities per min			

19. Heart: Is there any: Enlargement O Yes O No Dsypnea O Yes O No

Murmur(s) O Yes O No Edema O Yes O No

(Describe below – if more than one, describe separately.)

	Murmur #1	Murmur#2
Location:		
Constant	O	O
Inconstant	O	O
Transmitted	O	O
Localized	O	O
Systolic	O	O
Presystolic	O	O
Diastolic	O	O
Soft (Gr. 1 – 2)	O	O
Mod (Gr. 3 – 4)	O	O
Loud (Gr. 5 – 6)	O	O
After Exercise:		
Increased	O	O
Absent	O	O
Unchanged	O	O
Decreased	O	O

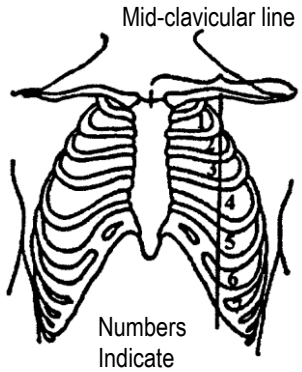
Indicate:

Apex by X

Murmur area by O

Point of greatest Intensity by O

Transmission by → For comments and Your impression



20. Is there on examination an abnormality of the following: (Circle applicable items and give details.)

a) Eyes, ears, nose, mouth, pharynx. O Yes O No
(If vision or hearing markedly impaired, indicate degree and correction.)

b) Skin (incl. scars), lymph nodes, varicose veins or peripheral arteries. O Yes O No

c) Nervous system (include reflexes, gait, paralysis). O Yes O No

d) Respiratory system. O Yes O No

e) Abdomen (include scars). O Yes O No

f) Genito-urinary system. O Yes O No

g) Endocrine system. (include thyroid and breasts). O Yes O No

h) Musculoskeletal system. (include spine, joints, amputations, deformities). O Yes O No

21. Are there any hernias? O Yes O No

22. Are you aware of any additional medical history for this proposed insured? O Yes O No
(A confidential report may be sent to the Medical Director.)

23.

Albumin	Sugar	Blood

If history or presence of albumin, sugar, kidney disease or stone, blood pressure over 150/90, send specimen to Foresters designated lab.

Are you sending a specimen? O Yes O No

Details of "Yes" answers. (Identify them.)

When completed mail to:
The Independent Order of Foresters
P.O. Box 179
Buffalo NY 14201-0179