

**PART II
 Medical Declaration**

PROPOSED INSURED (FIRST NAME, MIDDLE INITIAL, LAST NAME) _____

BIRTHDATE
 DAY MTH YR _____

APPLICANT'S NAME IF OTHER THAN THE INSURED.

1 a. Name and address of your personal physician? (If none, so state) _____
 b. Date and reason last consulted? _____
 c. What treatment was given or medication prescribed? _____

2. Have you ever been positively diagnosed or treated by a physician for:

	YES	NO
a. Disorder of eyes, ears, nose, or throat?	<input type="checkbox"/>	<input type="checkbox"/>
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e. Jaundice, hepatitis, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes; thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
i. Deformity, lameness or amputation?	<input type="checkbox"/>	<input type="checkbox"/>
j. Disorder of skin, lymph glands, cyst, tumor, or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
k. Allergies; anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
l. Excessive use of alcohol, or any habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS of "YES" answers.
 (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

3. Are you now under observation or taking treatment? YES NO

4. Has your weight changed more than 10 lbs. in the past year? YES NO

5. Within the last 12 months have you
 a. Smoked cigarette(s) or cigarillos? YES NO
 b. Smoked a pipe, cigars, or used tobacco in any form? YES NO

6. Have you ever been positively diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related illness? YES NO

7. Other than indicated above, have you within the past 5 years:
 a. Had any mental or physical disorder? YES NO
 b. Had a checkup, consultation, illness, injury, surgery? YES NO
 c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? YES NO
 d. Had electrocardiogram, X-ray, other diagnostic test? YES NO
 e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? YES NO

8. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? YES NO

9. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? YES NO

10. Family History: any diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? YES NO

	Age if Living?	Health	Cause of Death?	Age at Death?
Father				
Mother				
Brothers/ # Living . . .				
Sisters/ # Living . . .				

11. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? YES NO

To the best of my knowledge and belief, I hereby declare that the above answers and statements are correctly and fully recorded by the medical examiner and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

Dated at _____ on _____ DATE

In Presence of _____ MEDICAL EXAMINER _____ SIGNATURE OF PROPOSED INSURED

COMPLETE FOR IOF INTERNATIONAL HEADQUARTERS PAYMENT

Person Examined _____ Date Examined _____ Fee \$ _____

Name of Examiner _____ No. _____ Address _____
 (PLEASE PRINT) (PLEASE PRINT)
 Zip Code _____

If payment to be made to clinic or paramedical company show name and address:
 Name _____ Address _____
 (PLEASE PRINT) (PLEASE PRINT)
 Zip Code _____

MEDICAL EXAMINER'S REPORT

This examination should be made in private

12.a. Height (in shoes)		Weight (clothed)		Males Only;		
ft.	in.	lbs.		Chest (full inspiration)	Chest (force expiration)	Abdomen, at umbilicus
				in.	in.	in.

b. Did you weigh? YES NO Did you measure? YES NO
 c. Is appearance unhealthy or older than stated age? YES NO

DETAILS OF "YES" answers.
(Identify item.)

13. Blood Pressure (Record ALL readings)

Systolic			
Diastolic - 4th phase			
- 5th phase			

14. Pulse:

At Rest	After Exercise	3 minutes later

Rate _____
Irregularities per min. _____

15. Heart: Is there any:

Enlargement YES NO Dyspnea YES NO
 Murmur(s) YES NO Edema YES NO

(describe below - if more than one, describe separately)

Murmur # 1		Murmur # 2	
Location:			

Indicate:

Constant Apex by X
 Inconstant
 Transmitted
 Localized Murmur area by ○
 Systolic
 Presystolic
 Diastolic
 Soft (Gr. 1 - 2) Point of greatest intensity by ○
 Mod. (Gr. 3 - 4)
 Loud (Gr. 5 - 6)
 After Exercise:
 Increased Transmission by →
 Absent For comments and your impression
 Unchanged
 Decreased

Mid-Clavicular Line
Numbers indicate Interspaces

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

a. Eyes, ears, nose, mouth, pharynx?	YES	NO
(If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

17. Are there any hernias? YES NO
 18. Are you aware of additional history? YES NO
 (A confidential report may be sent to the Medical Director)

19. URINALYSIS

Albumin	Sugar	Blood

If history or presence of albumin, sugar, kidney disease or stone, blood pressure over 150/90, send specimen to:
 HOME OFFICE REFERENCE LABORATORY
 10310 West 84th Terrace, Lenexa, Kansas 66214

Are you sending a specimen? YES NO

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

I certify that I made this examination _____ A.M. _____ P.M. on _____ DATE _____

Examination made at my office applicant's office applicant's home Other _____

at request of Agent _____ SIGNATURE OF MEDICAL EXAMINER _____ DEGREE _____

OF - 145 - 90 (US-II) 100439 (5/99)
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THE INDEPENDENT ORDER OF FORESTERS
 International Headquarters
 789 Don Mills Road, Don Mills, ON M3C 1T9
 Telephone: (416) 429-3000 Fax: (416) 429-3896
 Toll-Free CAN 1-800-268-6091
 US 1-800-828-1540
US Mailing Address:
 P.O. Box 179, Buffalo, NY 14201-0179

NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING

To evaluate your insurability, we have requested that you provide samples of your blood and/or other body fluids for testing and analysis. Depending on your age, your medical history and the amount or the type of insurance applied for, you may be asked to provide a sample of blood and/or other body fluids, such as urine and saliva for testing and analysis. All tests will be performed by a licensed laboratory. By signing and dating this form, you agree that the testing may be done and that underwriting decisions will be based on the test results.

The tests to be performed will include a determination of the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test performed is actually a series of tests designed to determine the presence of these antibodies or antigens. If you have been infected with the HIV virus which causes AIDS, your body may have produced HIV antibodies which try to get rid of the infection.

Instead of providing a blood sample for initial testing purposes, you may be requested to first provide only a sample of your body fluids (e.g. urine or saliva) for testing. This sample of other body fluids will be tested for evidence of HIV antibodies, kidney disorders, diabetes, and foreign substances such as nicotine and cocaine. If this HIV test is abnormal (positive) or other abnormalities are ascertained, you then will be requested to provide a blood sample for full blood series testing including a confirmatory HIV blood test. Other blood tests which may be performed include determinations of blood cholesterol and related lipids (fats), and screening for diabetes, liver and kidney disorders.

TESTING CONSIDERATIONS:

Many public health organizations have recommended that before taking an HIV related test, a person seek counseling to become informed concerning the implications of such test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF A POSITIVE TEST RESULT:

The HIV test is extremely reliable. In very rare instances, however, the test result may be abnormal (positive) in persons who are not infected with the virus. Additionally, the test result may occasionally be normal (negative) in persons who are infected with HIV, especially when the infection occurred within the previous 3-6 months.

While abnormal HIV test results do not mean that you have AIDS, they do mean that you are at significantly increased risk of developing AIDS or AIDS-related conditions and you may wish to consider further independent testing. Federal authorities say that persons who are HIV positive should be considered infected with the AIDS virus and capable of infecting others. An abnormal (positive) HIV blood test result or other significant blood or body fluid abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

DISCLOSURE OF TEST RESULTS:

All test results will be treated confidentially. The results of the test will be reported by the laboratory to us. The test results may be disclosed to employees of the IOF who have the responsibility to make underwriting decisions on behalf of us or to outside legal counsel who need such information to effectively represent us with regard to your application for insurance. The results also may be reported to our affiliates or reinsurers in connection with insurance you have applied for. In addition, if you are refused insurance because your HIV blood test is abnormal (positive), a generic code signifying non-specific blood abnormality will be reported to the Medical Information Bureau, Inc. ("MIB") is described in the notice given to you at the time of application. More specific non-HIV reports may be made to MIB in connection with testing. Test results will not otherwise be disclosed except as required by law or as authorized by you. You have the right to request the names of those specific individuals or organizations.

NOTIFICATION OF TEST RESULTS:

If your HIV test results are normal, no notification will be sent to you. If your HIV tests are abnormal, we will contact you, your legal guardian, if any or the physician authorized by your below. Other abnormal test results which, in our opinion, are potentially significant to your health or insurability will be similarly communicated.

If you wish to preauthorize another person for notification of abnormal test results, please provide the name and address below. We encourage you to authorize a physician or other health care provider for the purpose of discussing test results:

NAME AND ADDRESS OF PHYSICIAN (Please Print):

INFORMED CONSENT:

I have read and I understand this NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and body fluid as described above, and the disclosure of the test results as described above, including disclosure to the physician, if any, indicated above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my physician or health care provider for further information and counseling if the HIV test result is abnormal. I have been give a copy of the state Hotline phone numbers and addresses (if available). I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be valid as the original.

NAME OF PROPOSED INSURED

BIRTHDATE

SIGNATURE OF PROPOSED INSURED (PARENT/GUARDIAN)

STATE OF RESIDENCY

DATE SIGNED BY PROPOSED INSURED (PARENT/GUARDIAN)

CONTINUED ON REVERSE SIDE