

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

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COVID-19 (Coronavirus) 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. “Advised”, “diagnosed” and “tested” mean by a licensed physician or medical practitioner. If additional space is required, an additional piece of paper can be attached, if signed and dated.

1. Within the past 30 days, have you been diagnosed with, or tested positive for, COVID-19 (Coronavirus)?
 Yes No
2. Within the past 30 days, has anyone living in your household been diagnosed with, or been individually directed or instructed to quarantine by a licensed physician, medical practitioner, or local or state health department for, COVID-19 (Coronavirus)?
 Yes No
3. Within the past 30 days, have you been individually advised to self-isolate or been individually directed or instructed to quarantine by a licensed physician, medical practitioner, or local or state health department, due to symptoms of, or for any other reason related to, COVID-19 (Coronavirus)?
 Yes No

I declare that I have reviewed this COVID-19 (Coronavirus) Questionnaire and represent that the information provided 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 and as such will be attached to and become part of the entire contract issued, if any, as a result of 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)