Asthma

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐Term ☐UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income:_____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis: _____
2. Have you ever been hospitalized for asthma: ____ No ____ Yes; Date(s): _____
3. How many episodes requiring an ER visit or to see your physician for treatment in the last year: _____
4. Please list any medications you take/use (including inhalers) for this condition including frequency:

   _____

   _____
5. Have you had pulmonary function tests: ____ No ____ Yes; Please give details of results:

   _____
6. Have you had any abnormalities on an ECG or X-ray: ____ No ____ Yes; Please give details of results:

   _____
7. Do you have any other health conditions or take any other medications: ____ No ____ Yes; Please give details:

   _____

   _____