

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 know the specific diagnosis related to your asthma?

___ Cough variant ___ Intermittent ___ Mild ___ Moderate ___ Severe

8. Do you have any other health conditions or take any other medications: ___ No ___ Yes; Please give details:

