



CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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. What is the type of lung disease?

Chronic bronchitis Emphysema Restrictive lung disease Asthma

2. Date first diagnosed: _____

3. Has your client ever been hospitalized for this condition? No Yes; please give details _____

4. Has your client ever smoked?

Yes, and currently smokes _____ (amount per day)

Yes, smoked in the past but quit _____ (date quit)

Never smoked

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Have pulmonary function tests (a breathing test) ever been done? No Yes; please give details : FEV1 (% predicted) _____

FEV1/FVC Ratio: _____

7. Client's build: Height: _____' _____" Weight: _____

8. Does your client have any abnormalities on an ECG or X-ray? No Yes; please give details _____

9. Does client have any other major health issues (heart disease, etc.)? (additional questionnaires may be required)

No Yes; please give details _____

10. Does your client require supplemental oxygen? ___ Yes ___ No

11. Are there any physical limitations due to shortness of breath? Please describe: _____

12. Any time off of work due to symptoms? ___ No ___ Yes: Frequency: _____