

Respiratory questionnaire

(by insured life)

Policy number

Member number*

Group number* (*Fill in for FundsAtWork)

1: Details of insured life

Name of insured life	<input type="text"/>																	
Permanent identity/passport number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Permanent identity number	Yes <input type="text"/>	No <input type="text"/>					
Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Financial adviser's name	<input type="text"/>										Financial adviser code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Broker house code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2: Symptoms of your respiratory condition

1. From what type of respiratory condition do you suffer (e.g. asthma, emphysema, chronic bronchitis, pulmonary tuberculosis, sarcoidosis etc.)?

2. How severe are your symptoms?

Mild <input type="text"/>	Moderate <input type="text"/>	Severe <input type="text"/>	No symptoms <input type="text"/>
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3. How often do your symptoms occur?
(you may indicate more than one option)

Daily <input type="text"/>	Weekly <input type="text"/>	Monthly <input type="text"/>	All year round <input type="text"/>
Autumn <input type="text"/>	Spring <input type="text"/>	Winter <input type="text"/>	Summer <input type="text"/>

4. What are your symptoms?
(you may indicate more than one option)

Coughing <input type="text"/>	Shortness of breath <input type="text"/>	Excessive mucus (phlegm) <input type="text"/>
Wheeziness <input type="text"/>	Tightness of the chest <input type="text"/>	Other <input type="text"/>

If "other", provide full details:

5a. At what age did your symptoms start?

5b. State month and year of last symptoms

6. Is your chest clear between attacks?

Yes No

If "no", provide full details:

7. State the number of attacks

Daily <input type="text"/>	Weekly <input type="text"/>	Monthly <input type="text"/>	Yearly <input type="text"/>	None <input type="text"/>
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8. Have you ever been hospitalised for any complications (e.g. uncontrolled asthma)?

Yes No

GP consultations <input type="text"/>	Date <input type="text"/>	Complications: <input type="text"/>
	Date <input type="text"/>	<input type="text"/>
Casualty visits <input type="text"/>	Date <input type="text"/>	Complications: <input type="text"/>
	Date <input type="text"/>	<input type="text"/>
Admission to ward or intensive care <input type="text"/>	Date <input type="text"/>	Complications: <input type="text"/>
	Date <input type="text"/>	<input type="text"/>

9. Have you ever been confined to bed or home due to your respiratory condition?

Yes No

If "yes", for how long?

10. Do you become short of breath on exertion?

Yes No

If "yes", provide full details:

11. Do you suffer from night time attacks/early morning tightness?

Yes No

If "yes", provide full details:

12. Do you have to rely excessively on inhaled bronchodilators for relief of symptoms?

Yes No

If "yes", state type of treatment, including brand name:

3: Treatment of your respiratory condition

1. Do you receive treatment for your condition?		Yes		No								
If "yes", state type of treatment and dosage, including brand name:												
Bronchodilator		Brand name:			Dosage:							
Inhaled steroid (cortisone)		Brand name:			Dosage:							
2. Into which category does your treatment fall?												
Only occasional treatment during attacks				Continuous treatment interrupted only for short periods								
Treatment over a period of months				Not currently on medication								
3. Was cortisone used in the above treatment periods?		Yes		No								
If "yes", state duration of cortisone treatment:												
4. Do you measure peak flow with a peak flow meter?		Yes		No								
Does it confirm good control?		Yes		No								
Is there marked variation in the measurements?		Yes		No								
If "yes", provide full details:												
5. Do you participate in sport?		Yes		No								
When participating in sport, does it cause symptoms?		Yes		No								
If "yes", provide full details:												
6. Have you ever been absent from work due to your respiratory condition?		Yes		No								
If "yes", provide date/s and details:												
7. Are there circumstances that aggravate your symptoms at the workplace?		Yes		No								
If "yes", provide full details:												
8. Are you allergic to any medication (e.g. aspirin) or any type of food?		Yes		No								
If "yes", provide full details:												
9. Is there ever any limitation of functional capacity, including ability to work?		Yes		No								
If "yes", provide date/s and details:												
10. Do you smoke or have you ever smoked?		Yes		No								
If "yes", provide details of existing and past smoking habits:												
Current smoking habits		per day	Previous smoking habits		per day	Gave up smoking	M	M	Y	Y	Y	Y
11. Have you ever had any of the following examinations?		Yes		No								
If "yes", provide date/s and results:												
Chest X-ray		Date	D	D	M	M	Y	Y	Y	Y	Results:	
Lung Function Test		Date	D	D	M	M	Y	Y	Y	Y	Results:	
If any other examinations have been done, provide type of examination/s date/s and results:												
		Date	D	D	M	M	Y	Y	Y	Y	Results:	
		Date	D	D	M	M	Y	Y	Y	Y	Results:	
12. Provide any further relevant details, including the name/s and address/es of any medical doctor/s or specialist/s referred to:												

4: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

Signature of insured life

Date

D

D

M

M

Y

Y

Y

Y

No payment for the completion of this form.