



Name of Proposed Insured: _____ Application/Policy No: _____

1. Have you ever had any indication of or sought advice or been treated for any disease or disorder of the lungs or respiratory system? Yes No **If yes**, please specify: Asthma Chronic cough
 Chronic Obstructive Pulmonary Disease (COPD) Pneumonia Emphysema Chronic bronchitis
 Bronchiectasis Other (please specify): _____

2. Do you have episodes of symptoms such as wheezing, coughing, shortness of breath? Yes No
If yes, please specify: a) Date of first episode: _____
b) Date of last episode: _____
c) Number of episodes, past 12 months: _____
d) Number of episodes, past 24 months: _____
e) Duration of episodes: _____
f) Severity of episodes: Mild Moderate Severe

3. a) Are you currently taking any medication or receiving any treatment for this condition? Yes No
If yes, provide date and details of treatment, name(s), dosage(s) and frequency of use of medication(s):

b) Provide name(s) and dosage(s) of medication prescribed for acute or symptomatic episodes: _____

4. Have you ever consulted an emergency room or been hospitalized for this condition? Yes No
If yes, advise date(s), reason(s) and name and address of hospital(s): _____

5. Have you been referred to a specialist for this condition? Yes No **If yes**, provide full name(s) and addresses of specialist(s) consulted, frequency of follow-up visits and date of last consultation: _____

6. a) Have you undergone any diagnostic tests? Yes No **If yes**, specify type(s), date(s), and results:
 Chest x-ray _____ Bronchoscopy _____
 Pulmonary function test _____ CT scan _____
 Peak flow test _____ Other (specify) _____
b) Have any tests or investigations been recommended? Yes No **If yes**, specify type(s) of test or investigation(s) and date(s) scheduled: _____

7. Between episodes, do you have any ongoing symptoms such as shortness of breath, wheezing or cough? Yes No
If yes: a) Describe symptoms: _____
b) Do symptoms occur: At rest On exertion Other (specify): _____
c) Advise frequency and severity of symptoms: _____
If no: How long have you been completely free of any symptoms? _____

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8. a) Have you ever coughed up blood? Yes No If yes, provide details: _____

b) Do you have chronic sputum production? Yes No

9. Have you ever used any form of tobacco or marijuana or used smoking cessation products or tobacco substitutes such as betel nuts, betel leaves, supari, paan, shisha or gutka? Yes No

If yes, provide details:

Type Used	Quantity Used	Frequency Of Use	Date Last Used

10. a) Do you have any of the following conditions? Hay fever Nasal polyps Sinusitis

b) Do you have exercise or cold induced asthma? Yes No

c) Have you had pneumonia or bronchitis? Yes No If yes, specify number of episodes and date of last occurrence of each: _____

11. Is there a known allergic basis to your symptoms? Yes No

If yes, indicate allergens: _____

12. Have you ever lost any time from work due to this condition? Yes No

If yes, provide details including dates and duration of time off work: _____

13. Have your job duties or daily activities ever been restricted or modified in any way because of this condition?

Yes No If yes, describe restrictions, modifications or limitations: _____

14. Other than those already declared, please provide the full names and addresses of all doctors, health care professionals, hospitals or health care facilities consulted for this condition and the dates of consultations:

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: _____ Date: _____

Day/Month/Year