



# INSURANCE MARKETING SERVICES

PRODUCTS SERVICE AND TECHNOLOGY

## *Pulmonary Disease Questionnaire*

**Information gathered will be used in the evaluation of the insurability of the applicant. Offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.**

**Agent's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
**Proposed Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_\_\_  
**Male ( ) Female ( ) Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Smoker ( ) Non Smoker ( )**  
**Amount of Coverage \$** \_\_\_\_\_ **Product Type** \_\_\_\_\_

1. Type of lung disease

- Chronic bronchitis
- Emphysema
- Restrictive lung disease
- Asthma

2. Please list date when first diagnosed \_\_\_\_\_

3. Has the client ever been hospitalized for this condition?  Yes  No  
If yes, please give date \_\_\_\_\_

4. Has the client ever smoked?

- Yes, and currently smokes \_\_\_\_\_ (amount/day)
- Yes, smoked in the past but quit \_\_\_\_\_ (date)
- No, never smoked

5. Is your client on any medication or an inhaler for the disease?  Yes  No  
If yes, please give details \_\_\_\_\_

6. Has the client had a recent pulmonary function (breathing test)?  Yes  No  
If yes, please give results \_\_\_\_\_

7. Does the client have any abnormalities on an ACG or X-ray?  Yes  No  
If yes, please detail \_\_\_\_\_

8. Has a parent, brother or sister died prior to age 65, other than by accident?  Yes  No  
If yes, please detail \_\_\_\_\_

9. Does the client exercise three or more times per week? [ ] Yes [ ] No

If yes, please detail \_\_\_\_\_

10. Client's occupation \_\_\_\_\_

11. Please list any other illnesses or impairments; along with any and all medications currently being taken, include the dosage and frequency of each: \_\_\_\_\_

\_\_\_\_\_