Assumption Life

Reset

Respiratory Disorder Questionnaire

First Name : _____ Last Name : _____

Policy Number : _____ Date of Birth (DD/MM/YYYY): ____/____/_____

1. Medical diagnosis : ☐ asthma ☐ bronchitis ☐ emphysema ☐ pneumonia ☐ other : _____

2. Please indicate which of the following apply to your condition, and provide us with further details :

Symptoms	**Details (dates and results)**
☐ Chronic cough	
☐ Sputum (yellowish-greenish color)	
☐ Sputum (with presence of blood)	
☐ Wheezing	
☐ Shortness of breath	
☐ Other_____	

Treatment / Surgery	**Details (dates and results)**
☐ Antibiotic	
☐ Inhaler(s) / puffer(s)	
☐ Maximist	
☐ Oral medication	
☐ Surgery (specify): _____	
☐ Oxygen	
☐ Other: _____	

3. Are you currently taking any medication? If yes, please provide details. ☐ Yes ☐ No

Name of Medication	**Dosage**	**Quantity per Day**	**Quantity per Month (if taken as needed)**

4. Date you first experienced symptoms or attacks : _____

5. Frequency of symptoms or attacks : _____

6. Date of your last symptoms or attack(s) : _____

7. Was any hospitalization required for any of these conditions? ☐ Yes ☐ No
If yes, dates and duration: _____

8. Was any time off work required for any of these conditions? ☐ Yes ☐ No
If yes, dates and duration: _____

9. Do you have any pending consultation, treatment or surgery? ☐ Yes ☐ No
If yes, please provide details (date, treatment, name of attending physician). _____

10. Name and address of your attending physician: _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

_____ _____

Signature of proposed insured (parent or legal guardian if a minor) Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 855-230-2500