Respiratory Questionnaire

For Asthma, please use the Asthma Questionnaire

Application Reference Number

The questionnaire must be completed by the Life Insured.

Important: No compensation is payable if a Medical Examiner completes this questionnaire.

Particulars of Life Insured

First Name(s)

Last Name

Identity No./Passport No. Compulsory

Date of birth dd/mm/yyyy

Address

Information regarding condition

1 Do you, or have you ever suffered from: ☐ bronchitis ☐ emphysema ☐ a chronic cough ☐ pneumonia

☐ Other (explain)

2 Date of first instance of each condition

3 How often do episodes occur and how long do they last?

4 Please state the date of your last episode

5 Would you describe the episodes as: ☐ mild ☐ moderate ☐ severe ☐ productive of sputum ☐ blood

6 Have you lost any time from work? ☐ Yes ☐ No

If you have answered 'Yes', please state the duration of absence and nature of diagnosis or reason for your absence.

Please provide the address of your workplace:

7 Have you ever been hospitalised? ☐ Yes ☐ No

If you have answered 'Yes', state the location and duration of hospital stay and nature of your diagnosis.

8 Are you currently receiving treatment or taking medication, or have you been advised to be? ☐ Yes ☐ No

If you have answered 'Yes', state the name and type of medication, and amount and frequency of dosage.

9 Please state the names and addresses of all doctors consulted. You should provide as much information as possible, such as dates, symptoms, diagnoses and treatment.

10 Do you experience: ☐ shortness of breath ☐ wheezing

Other symptoms (please explain)

11 If 'Yes', how often does this occur? What do you think precipitates the episode?

12 Do you use tobacco in any form? ☐ Yes ☐ No ☐ No, but a former user

If you have answered 'Yes', please state the type and daily quantity of tobacco usage.

If you are a former tobacco user, please state the duration and quantity of your tobacco usage, and the date when you gave up smoking.

Declaration by Life Insured

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Signature

Date dd/mm/yyyy

UL Respiratory Question 07.17

If you require any further details, please ask your financial adviser.
Alternatively you can contact your nearest Unilife office, details of which are available on our website, or get in touch using our email address:
administration@unihealthandlife.com