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) When was the diagnosis of asthma made?

2) When do your symptoms occur? (Please tick box(es) as applicable.)

☐ Seasonally ☐ Due to infections of the air passage ☐ During exercise ☐ At any time

If applicable, when would you say that your symptoms last occured?

3) How often do your consult a doctor regarding your asthma symptoms? ☐ 5 times or less a year ☐ More than 5 times a year

4) Are you currently receiving treatment for your asthma? ☐ Yes ☐ No

If you have answered 'Yes', please complete the following table:

Treatment	Name of Medication	Frequency of Dosage
Inhalers		
Tablets		
Syrup		
Nebulizer		
Injections		
Cortisone		
Medication only when necessary		
Medication before exercise		

If you have answered 'No', state when and what kind of medication was last taken.

If you answer 'Yes' to any of the following questions, please provide more details in the space provided below.

5) Has it been necessary to change either your medication or its dosage during the past 2 years? ☐ Yes ☐ No

Please provide further details:

6) Have you ever been hospitalised for asthma **during the past 2 years**? ☐ Yes ☐ No

Please provide further details:

7) Have you consulted a doctor regarding acute asthmatic symptoms **during the past 2 years**? ☐ Yes ☐ No

Please provide further details:

8) Do you consult your doctor at regular intervals for check-ups for your asthma? ☐ Yes ☐ No

Please provide further details:

9) Have you had any lung function tests? ☐ Yes ☐ No

What were the test results?

10) Would you say that your work environment has an influence/effect on your asthma? ☐ Yes ☐ No

Please provide further details:

11) Have you been on sick leave due to your asthma **during the past 5 years**? ☐ Yes ☐ No

Please provide further details:

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.

13) Please provide the details of any doctor(s) consulted due to your asthma during the past 5 years.

Full name of doctor	Address

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