CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

CLIENT NAME: _____ **Date:** _____

❑ Male ❑ Female Date of birth: _____ Height: _____ ' _____ " Weight: _____

Tobacco Use: ❑ Never used ❑ Totally stopped Date stopped: _____ ❑ Use now Type of nicotine product: _____

Type of Coverage: ❑ Term ❑ UL ❑ Survivor **Type of Coverage:** ❑ Term ❑ UL ❑ Survivor

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death.

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. What is the type of lung disease? ❑ Chronic bronchitis ❑ Emphysema ❑ Restrictive lung disease ❑ Asthma

2. Date first diagnosed: _____

3. Has your client ever been hospitalized for this condition? ❑ No ❑ Yes; please give details

_____

_____

4. Has your client ever smoked?

❑ Yes, and currently smokes _____ (amount per day)

❑ Yes, smoked in the past but quit _____ (date quit)

❑ Never smoked

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Have pulmonary function tests (a breathing test) ever been done? ❑ No ❑ Yes; please give details

_____

_____

7. Client's build: Height: _____ ' _____ " Weight: _____

8. Does your client have any abnormalities on an ECG or X-ray? ❑ No ❑ Yes; please give details

_____

_____

9. Does client have any other health issues? (additional questionnaires may be required) ❑ No ❑ Yes; please give details

_____

_____