Respiratory (Asthma) Questionnaire

(to be completed by the Insured)

Policy Number:

Name of Insured: _____ Date of birth: _____ (DD/MM/YYYY)

1 Have you ever suffered from bronchitis, asthma, chronic obstructive pulmonary disease? ..... ○ Yes ○ No

Date of first attack: _____ (DD/MM/YYYY) Date of last attack: _____ (DD/MM/YYYY)

Frequency of attacks: _____ Average duration: _____

2 Are the attacks: ☐ mild? ☐ moderate? ☐ severe?

Have you ever coughed up blood? ..... ○ Yes ○ No

Are you short of breath? ..... ○ Yes ○ No

Do you wheeze on exertion? ..... ○ Yes ○ No

3 What medication or treatment have you required (Inhalers, Cortisone, Prednisone or other steroids)?

_____

4 Have you had lung or pulmonary function tests? ..... ○ Yes ○ No

If results are known are they Normal or Abnormal? _____

Have you had chest x-rays? ..... ○ Yes ○ No

If results are known are they Normal or Abnormal? _____

5 a) Have you lost time from work? ..... ○ Yes ○ No

Date ceased work: _____ (DD/MM/YYYY) Date resumed work: _____ (DD/MM/YYYY)

b) Were you hospitalized? ..... ○ Yes ○ No

From _____ to _____ Name of hospital: _____

6 Please give names and addresses of all your attending doctors, with dates in each instance:

_____

_____

7 a) Do you smoke? ○ Yes ○ No If ***"Yes,"*** explain and state daily quantity: _____

b) Have you ever smoked? ○ Yes ○ No If ***"Yes,"*** when did you last smoke? _____ (DD/MM/YYYY)

8 Additional Comments: _____

_____

_____

I understand that my answers to the above questions will be relied on by ivari in establishing my premium rate. If the above answers are not true, complete and correctly recorded, any policy issued as a result of this questionnaire may be rendered void on the grounds of misrepresentation or fraud.

I hereby declare that I have read all the questions and answers in this questionnaire and the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief. I understand and agree that this questionnaire shall form part of my Insurance Application to ivari.

Dated at (city) _____ in the province of _____ on _____ (DD/MM/YYYY)

_____ _____

Signature of Insured Signature of Witness

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