RESPIRATORY DISORDERS QUESTIONNAIRE

DATE:_____ ADVISOR NAME: _____
PHONE:_____ FAX:_____ EMAIL:_____

CLIENT INFORMATION:

PROPOSED INSURED:_____ DATE OF BIRTH:____/____/____

☐ MALE ☐ FEMALE STATE OF SALE:_____

OTHER COMPANY ACTIONS: ☐ RATED TABLE____ ☐ POSTPONED ☐ DECLINED

OTHER COMPANY DETAILS:_____

ANY WEIGHT CHANGE IN THE LAST YEAR? ☐ NO ☐ YES - HOW MUCH?_____
REASON FOR CHANGE?_____

TYPE OF RESPIRATORY DISORDER OR DISEASE:
☐ CHRONIC BRONCHITIS ☐ EMPHYSEMA ☐ RESTRICTIVE LUNG DISEASE
☐ ASTHMA ☐ OTHER:_____

DATE OF DIAGNOSIS:____/____/____

HAS THE PROPOSED ENSURED EVER SMOKED CIGARETTES?
☐ YES - HOW MUCH?_____ ☐ NO ☐ QUIT WHEN_____

HAS A PULMONARY FUNCTION TEST BEEN PERFORMED? ☐ NO ☐ YES - WHEN?_____
RESULTS:_____

HAS A CHEST X-RAY OR EKG BEEN PERFORMED? ☐ NO ☐ YES - WHEN?_____
RESULTS:_____

HOW MANY EPISODES HAS THE PROPOSED INSURED HAD IN THE PAST YEAR THAT REQUIRED THEM TO VISIT THE EMERGENCY ROOM OR SEE THEIR PHYSICIAN FOR TREATMENT?_____

HAS THE PROPOSED INSURED EVER BEEN HOSPITALIZED FOR THIS CONDITION? ☐ NO ☐ YES
IF YES, PLEASE PROVIDE DETAILS (DATES, HOSPITALS, ETC.):_____

HOW IS CONDITION BEING TREATED (BREATHING MACHINE, OXYGEN, MEDICATIONS, ETC.)?_____

PLEASE LIST ANY MEDICATIONS BEING TAKEN (INCLUDING INHALERS AND MEDICATIONS USED "AS NECESSARY"):

DOES PROPOSED INSURED HAVE ANY RESTRICTIONS ON DAY-TO-DAY ACTIVITIES? ☐ NO ☐ YES
IF YES, PLEASE PROVIDE DETAILS:_____

DOES PROPOSED INSURED HAVE ANY OTHER MAJOR HEALTH PROBLEMS? ☐ NO ☐ YES
IF YES, PLEASE PROVIDE DETAILS:_____

Please return via email at
PlusMarketing@pfnins.com

PLUS FINANCIAL NETWORK
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