Sagicor

RESPIRATORY QUESTIONNAIRE

(To be completed by Proposed Insured)

Name of Proposed Insured:	Policy No:

1. Do you, or have you ever suffered from: ☐ Bronchitis ☐ Asthma ☐ Emphysema ☐ Chronic Cough ☐ Pneumonia ☐ Others (Explain)

_____

_____

2. Date of first attack of each? _____

_____

3. How often do attacks occur and last? _____

4. Date of last attack? _____

5. Are attacks: ☐ Mild ☐ Moderate ☐ Severe ☐ Productive of Sputum ☐ Blood

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

   If yes, when, how long, why? _____

   _____

7. Have you ever been hospitalized? ☐ Yes ☐ No

   If yes, when, where and diagnosis and for how long: _____

   _____

8. Are you now under treatment or taking medication or been advised to be? ☐ Yes ☐ No

   If yes, type and quantity: _____

   _____

9. Names and address of all doctors consulted. Please give dates, symptoms, diagnoses and treatment:

Date(s)	Name(s)	Address(es)	Symptoms	Diagnoses	Treatment

10, Do you experience: ☐ Shortness of breath ☐ Wheezing ☐ Others (Explain)

_____

11. If yes, how often and what precipitates the attack? _____

12. Do you use tobacco in any form? ☐ Yes ☐ No

If yes, quantity per day: _____

If no, but used to: for how many years, quantity and date of last usage: _____

_____

I hereby agree that this supplement shall form a part of the application and of the policy issued thereunder, if any, and that it shall be binding on any person or persons who shall have or claim any interest under such policy. I have carefully read the above questions, statements, and answers and all such statements and answers are correctly recorded and are true as written above.

Dated this _____day of _____,20_____

_____	_____	_____
Advisor/Witness	Signature of Proposed Insured	Applicant *(if other than Proposed Insured)*