financial life

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RESPIRATORY QUESTIONNAIRE

TO BE COMPLETED BY THE PROPOSED INSURED

Name of Proposed Insured: ______________________________ DOB: ______________
MM/DD/YYYY

1) Have you ever been diagnosed, treated, or been given medical advice by a member of the medical profession for:
☐ Bronchitis ☐ Asthma ☐ COPD ☐ Emphysema ☐ Other: ______________

2) Date of your first attack? ______________

3) How often per year do attacks occur? ______________

4) What was the date of your last attack? ______________

5) Are your attacks seasonal? ☐ No ☐ Yes

6) Is disease considered: ☐ Mild ☐ Moderate ☐ Severe

7) Please list all physicians that have treated you for your respiratory condition, provide names and addresses:

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8) Have you ever been hospitalized or seen in the Emergency Room due to your respiratory condition?
☐ No ☐ Yes If yes, provide dates, names, and addresses for all treatment locations:

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9) Have you received treatment or been prescribed medication of any kind by a member of the medical profession (including oxygen and steroids)?
☐ No ☐ Yes If yes, provide details, including medications taken and when last used:

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10) Do you currently experience shortness of breath or do you wheeze on exertion? ☐ No ☐ Yes

11) Do you use tobacco? ☐ No ☐ Yes If yes, what type and how much per day?

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12) Please provide any additional information you feel is important concerning your respiratory condition:

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I understand that this declaration will be relied upon by the National Catholic Society of Foresters in determining my insurability. I understand that any material misstatement in this declaration, or elsewhere, could render the policy, if issued, voidable. I declare that the above answers are true and complete to the best of my knowledge and belief.

______________________________ ______________
SIGNATURE OF PROPOSED INSURED DATE

If age 16 or over, or Parent or Guardian if under age 16 or the age of majority required by the state where the policy is issued for delivery.