

Identification

Policy No.:

Name of person to be insured:

First Name of person to be insured:

Date of birth: / /
year / month / day

Section Respiratory disorder

1. Type of disorder: Bronchitis Asthma Emphysema Other: _____

2. Date of first episode: / /
year / month / day

Date of last episode: / /
year / month / day

Frequency of episodes in the past a) 12 months _____ b) 24 months _____

How long do the episodes last? _____

3. What is the severity of your condition? Mild Moderate Severe

4. Have you ever lost any time off work because of this condition? Yes No

If Yes, state frequency and duration: _____

5. Are you currently taking any medication or has any medication been prescribed? Yes No

If Yes, list all medications taken or prescribed, the dosage of each and the frequency of use _____

6. Have you ever been hospitalized or seen in emergency (ER) for this condition? Yes No

If Yes, list date and duration for each occasion: _____



Respiratory disorder (...continued)

7. In the past 5 years have you had a chest X-ray, pulmonary function test or any other tests? Yes No

If yes, state the name, date and results for each test:

8. Are you short of breath or do you wheeze between episodes? Yes No

If yes, does it happen At rest On exertion Both at rest and exertion

9. Have you ever coughed up blood? Yes No

10. Do you smoke? Yes No

a) If yes, have you ever been advised by a medical professional to stop smoking? Yes No

b) If yes, state the type and amount of tobacco products or marijuana used:

11. Do you have a cough? Yes No

12. Do you have a known respiratory allergy? Yes No

13. Are you currently having any symptoms? Yes No

14. Are you currently under any treatment? Yes No

If you have answered "Yes" to questions 9 to 14, provide full details below:

(Indicate the question number followed by details and name and address of any doctor, hospital or other health care professionals consulted)

I, the undersigned, declare that the above answers are true and complete and shall form part of my application for insurance with Humania Assurance.

Signed at: _____

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
year					month			day	

Signature of witness: _____

Signature of person to be insured: _____