



Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of birth: _____

Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship

Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

(1) *Date of diagnosis:* _____

(2) *Type of lung disease diagnosed with Chronic Obstructive Pulmonary Disease (COPD):*

Asthma Chronic Bronchitis Emphysema Restrictive lung disease Other: _____

(3) *Has the proposed insured ever been hospitalized for the condition?* No Yes Date(s): _____

(4) *Is the proposed insured taking medications (incl. inhalers and oxygen)?* No Yes If yes, please give details:

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(5) *Has a pulmonary function test (breathing test) ever been done?* No Yes

If yes, please provide most recent date: _____ Are any test results known? _____

(6) *What is the proposed insured's build?* Height: _____ Weight: _____

(7) *Has a Chest X-ray been done?* No Yes Date: _____ Findings: _____

(8) *Has a ECG been done recently?* No Yes Date: _____ Findings: _____

(9) *Are there any other medical conditions affecting the proposed insured?* If yes, please describe in detail below:
