

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

CLIENT NAME:			
☐ Male ☐ Female Date of birth:	Height:'	" Weight:	
Tobacco Use : □ Never used □ T	otally stopped Date stopped:	Use now	Type of nicotine product:
Type of Coverage: □ Term □ UL □ Survivor Type of Coverage: □ Term □ UL □ Survivor UL			
Coverage Amount:	Anticipated	l Premium:	
FAMILY HISTORY			
Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide? If yes, use separate sheet to provide this information, including age of onset and date of death			
PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?
1. What is the type of lung disease? ☐ Chronic bronchitis ☐ Emphysema ☐ Restrictive lung disease ☐ Asthma			
2. Date first diagnosed:			
3. Has your client ever been hospitalized for this condition? No Yes; please give details			
4. Has your client ever smoked?			
☐ Yes, and currently smokes (amount per day)			
☐ Yes, smoked in the past but quit (date quit)			
□ Never smoked			
5. Is client on any medications now? (accurate name, dosage, and reason)			
(Accurate) Name of Medication	Dosage	Reason	
6. Have pulmonary function tests (a breathing test) ever been done? No Yes; please give details			
7. Client's build: Height: Weight:			
8. Does your client have any abnormalities on an ECG or X-ray? \square No \square Yes; please give details			
9. Does client have any other major health issues (heart disease, etc.)? (additional questionnaires may be required)			
□ No □ Yes; please give details			