UV INSURANCE

NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

RESPIRATORY DISORDER QUESTIONNAIRE

1. Do you or have you ever suffered from:

☐ Asthma ☐ Chronic Bronchitis ☐ Chronic Obstructive Bronchitis ☐ Bronchiectasis
☐ Emphysema ☐ Allergies (which?):_____

2. CRISIS, ATTACKS OR RESPIRATORY DIFFICULTY
(We understand by these terms, any moment you need medication or use a bronchodilator)

a) Date of first attack: _____/_____/_____ (D / M / Y) **Date of the last attack:** _____/_____/_____ (D / M / Y)

b) Frequency of attacks: _____

c) At which time of the year do you suffer your attacks? _____

d) Are the attacks: ☐ Mild ☐ Moderate ☐ Severe

3. Are you completely free of any respiratory disorders between attacks? ☐ Yes ☐ No
If no, indicate the symptoms: ☐ Shortness of Breath ☐ Cough ☐ Rale ☐ Expectoration
☐ Hemoptysis (spitting of blood) ☐ Exercise Induced Wheezing

4. To the best of your knowledge what is the cause of your respiratory disorders?
☐ Viral Respiratory Infection ☐ Emotional Crisis ☐ Exercise ☐ Cold/Cool Air
☐ Allergies (pollens, animals, etc.) ☐ Environmental Irritants (smoke, odours, paints, tobacco, etc.)

5. Are you currently under any treatments or taking any medications? ☐ Yes ☐ No
If yes: Name/Type:_____Frequency:_____ ☐ As needed ☐ Daily
Name/Type:_____Frequency:_____ ☐ As needed ☐ Daily
Name/Type:_____Frequency:_____ ☐ As needed ☐ Daily

6. Have you or do you require cortisone or any similar medications? ☐ Yes ☐ No
If yes, specify the date and the duration of the treatment:_____

7. Have you ever been hospitalized? ☐ Yes ☐ No **If yes**, where, date and duration: _____

_____

8. Have you been treated in emergency in the last year? ☐ Yes ☐ No
If yes; where and how often: _____

9. Examinations and results:
- Chest X-RAY _____
- Bronchoscopy _____
- Pulmonary Function Test _____
- Others _____

10. Name(s) and address(es) of your doctor(s) and date of the last consultation: _____

_____

11. Do you use tobacco in any form? ☐ Yes ☐ No **If yes**, type and quantity per day? _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ X_____
SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X_____ _____
WITNESS **DATE**

UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.