HUMANIA ASSURANCE MD®

Respiratory disorder questionnaire

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 precribed? ☐ 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: __________

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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 adress of any doctor, hospital or other health care professionals consulted)

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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: ☐☐☐☐ / ☐☐ / ☐☐ (year / month / day)

Signature of witness: ______________________

Signature of person to be insured: ______________________

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

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