

**Agent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_ (M or F): \_\_\_\_\_ Age: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max Premium \$: \_\_\_\_\_ / year Type: (UL, WL, Term, or Survivorship) \_\_\_\_\_

Do you currently smoke cigarettes? (Y or N): \_\_\_\_\_ If no, did you ever smoke: (Y or N): \_\_\_\_\_ Quit date: \_\_\_\_\_

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

If Yes, please provide details: \_\_\_\_\_

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

Date of Diagnosis: \_\_\_\_\_ What type of asthma has been diagnosed: \_\_\_\_\_

Do you know what leads to the asthmatic attacks? If so, please describe: \_\_\_\_\_

**Please describe the frequency of attacks and how often they have occurred:**

When did the attacks occur? (Y or N) \_\_\_\_\_ Number of attacks per year: (if continuous, please state so)

During the past year \_\_\_\_\_

During past 2 years \_\_\_\_\_

During past 3 years \_\_\_\_\_

4 years or more \_\_\_\_\_

**Have you ever been hospitalized due to severe asthma attacks? If so, please tell us about your hospital stay:**

Date(s) of hospitalization	How long were you at the hospital?	Were there any special circumstances?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**What medication were/are being used to control the asthmatic attacks (or any other condition)?**

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

**Please list any other medical information that may help provide a more realistic preliminary assessment:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_