MADISON™ BROKERAGE
The Advisor's Advisor
ACRISURE® PARTNER

PULMONARY DISEASE QUESTIONNAIRE

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: _____

Type of lung disease diagnosed with Chronic Obstructive Pulmonary Disease (COPD): (Y or N):

Asthma _____ Chronic Bronchitis _____ Emphysema _____ Restrictive lung disease _____

Other: _____

Has the proposed insured ever been hospitalized for the condition? (If Y, Dates) _____

Is the proposed insured taking medications (incl. inhalers and oxygen) (If Y, Details) _____

_____

Is the proposed insured taking any medications?

Name of Medication (Prescribed or OTC):	Dates Used:	Quantity:	Frequency:

Has a pulmonary function test (breathing test) ever been done?

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

What is the proposed insured's build? Height: _____ Weight: _____

Has a Chest X-ray been done? (Y or N): _____ Findings: _____

Has a ECG been done recently? (Y or N): _____ Findings: _____

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

_____

_____

_____

_____