GENERALI Central
LIFE INSURANCE

Asthma / Bronchitis / Respiratory Disorder Questionnaire

(To be filled by Proposer)

Name of the Life Insured	
Application Number	

Please answer each question and, wherever appropriate, provide details and attach copies of reports.

1. Are you suffering from or have you suffered from any respiratory disease? ☐ Yes ☐ No

   If 'Yes' since when? What was the diagnosis? _____

   If suffering from asthma, or bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis or bronchiectasis, please tick whatever is applicable and share the following details:

   How many attacks do you get in one year? _____ When was your last attack? _____

2. Please describe your symptoms: _____

   a) How frequently do these symptoms occur? _____

   b) Do your symptoms wake you up at night? ☐ Yes ☐ No

      If 'Yes' how often per month? _____

   c) Are your attacks seasonal? ☐ Yes ☐ No

      If 'Yes' during which season do your symptoms worsen? _____

      Number of attacks during the season: _____

3. What treatment are you on at present? State the name of the medication and dosage: _____

   _____

4. Have you ever taken corticosteroids, Steroids, e.g. Beclomethasone, Prednisolone, etc.? ☐ Yes ☐ No

   If 'Yes', please mention when: _____

   Type of treatment: _____ ☐ Inhaler ☐ Tablets ☐ Syrups

   Dosage: _____

5. Are you aware of any allergies to any substance, weather or other conditions that trigger symptoms? ☐ Yes ☐ No

   If yes, please state the conditions 1. _____ 2. _____ 3. _____

6. Do you consume alcohol or smoke or use tobacco in any form? ☐ Yes ☐ No

   If 'Yes':

   a) How many cigarettes/bidis/cigars/pipes do you smoke per day? _____

   b) How much alcohol do you consume per day? _____ ml/day

   c) Your alcohol of choice: Wine / Beer / Whiskey / Gin / Rum / Vodka / Spirit.

7. Have you ever been admitted to a hospital for emergency care in the last five years? ☐ Yes ☐ No

   If 'Yes': a) When? _____

   b) For how many days? _____

   **Please provide the hospitalisation reports and discharge summary.

8. Please mention the distance you can walk or the number of stairs you can climb without becoming breathless.

   Distance: _____ Kms _____ Number of stairs: _____

9. Have you had x-rays, PFT or any other investigations for this condition? ☐ Yes ☐ No

   If 'Yes' please provide the date and duration: _____

10. Have you ever taken time off-work because of this condition? ☐ Yes ☐ No

    If 'Yes', please provide the date and duration: _____

11. Please provide the name and address of your physician along with the latest follow-up notes: _____

    _____ Date of your last consultation: _____

12. Please provide any additional information that would help in processing your application: _____

** Please submit any blood tests, x-rays of chest, CT scan of chest, PFT records or any other tests done in the last one year including all follow-up consultation notes of your physician.

I hereby declare, and agree that the above particulars and answers are complete and true; and this questionnaire will form a part of the contract of the desired insurance on my life.

Place: _____

Date: _____

_____

Signature of the Life Insured

**Please tick ✓ wherever applicable.

Vernacular declaration: I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: _____

Address of the Declarant: _____

_____

_____
Signature of the Declarant

Place: _____ Date: _____

_____
Signature of the Life Insured