



PULMONARY DISEASE QUESTIONNAIRE  
***Global Insurance Resources Group Inc.***  
 9744 WILSHIRE BOULEVARD SUITE 306, Beverly Hills, CA 90212  
 PHONE (310) 550-3300 FAX (310) 550-3390

CLIENT: NAME \_\_\_\_\_ [ ] M [ ] F, DATE OF BIRTH \_\_\_\_\_

AGE \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ STATE \_\_\_\_\_

AMOUNT REQ. \$ \_\_\_\_\_ MAX. ANNUAL PREMIUM \$ \_\_\_\_\_

TYPE OF INSURANCE: [ ] PERM [ ] TERM YRS. LEVEL \_\_\_\_\_

TOBACCO USE: [ ] NO [ ] YES, DETAIL \_\_\_\_\_

REPLACING? [ ] NO [ ] YES CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR: \_\_\_\_\_ COMPANY \_\_\_\_\_  
 ACTION \_\_\_\_\_

AGENT: NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**1. TYPE OF LUNG DISEASE:**

- [ ] CHRONIC BRONCHITIS
- [ ] EMPHYSEMA
- [ ] RESTRICTIVE LUNG DISEASE
- [ ] ASTHMA

**2. PLEASE LIST DATE WHEN FIRST DIAGNOSED \_\_\_\_\_**

**3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?**

[ ] NO, [ ] YES, IF YES, PLEASE GIVE DATE \_\_\_\_\_

**4. HAS THE CLIENT EVER SMOKED?**

- [ ] YES, AND CURRENTLY SMOKES \_\_\_\_\_ (AMOUNT/DAY)
- [ ] YES, SMOKED IN THE PAST BUT QUIT \_\_\_\_\_ (DATE)
- [ ] NO, NEVER SMOKED

**5. IS YOUR CLIENT ON ANY MEDICATION OR AN INHALER FOR THE DISEASE:**

[ ] NO [ ] YES, IF YES, PLEASE GIVE DETAILS:

\_\_\_\_\_

**6. HAS THE CLIENT HAD A RECENT PULMONARY FUNCTION (BREATHING TEST)?**

[ ] NO [ ] YES, IF YES, PLEASE GIVE DETAILS:

\_\_\_\_\_

**7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON AN ACG OR X-RAY?**

[ ] NO [ ] YES, IF YES, PLEASE GIVE DETAILS:

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**8. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65 OTHER THAN BY ACCIDENT?  
[ ] NO [ ] YES, IF YES, PLEASE GIVE DETAILS:**

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**9. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?  
[ ] NO [ ] YES, IF YES, PLEASE GIVE DETAILS:**

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**10. CLIENT'S OCCUPATION;**

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**11. PLEASE LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ANY AND ALL  
MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF  
EACH:**

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