BROKERAGE GROUP INTERNATIONAL, LLC

Asthma Questionnaire

Broker Name: _____ Date: _____

Phone: _____ Fax: _____

E-Mail: _____

Address/City/State/Zip: _____

CLIENT INFORMATION

Name: _____ ☐ M ☐ F

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____

Insurance Amount _____ Insurance Type: ☐ Term ☐ Universal Life ☐ Whole Life

Death Benefit: _____ ☐ Second to Die ☐ Variable

Have you ever used tobacco or nicotine products? ☐ Yes ☐ No

If yes, what type of product did you use? ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Other

ASTHMA INFORMATION

1. Date of first symptoms? _____ _____
2. When did you last see the doctor for this condition? _____
3. Date of most recent breathing tests? _____
4. Have you been hospitalized?
   a. ☐ Yes ☐ No
   b. When (list all)? _____
5. Are you taking any medication?
   a. ☐ Yes ☐ No
   b. Name of RX? _____
   c. Do you use oxygen? ☐ Yes ☐ No
6. Are you disabled? ☐ Yes ☐ No
7. Are you limited by your lungs? ☐ Yes ☐ No
8. Additional Comments? _____

   _____

   _____