Desjardins Insurance
Life • Health• Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

QUESTIONNAIRE FOR PULMONARY AND BRONCHIAL DISEASES

First name and last name	Date of birth			Reference number: Case ID, Policy no., Contract no. or Application no.
	Y	M	D	

1. From which pulmonary or bronchial disease(s) do you suffer?

☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Fibrosis ☐ Occupational lung disease ☐ Other

Additional details: ____________________

Date of initial symptoms: ____________ (month/year) Date of diagnosis: ____________ (month/year)

Frequency of attacks: ____________ (times/year) Date of last attack: ____________

2. Have you ever been:
hospitalized for this problem? ☐ Yes ☐ No treated at emergency? ☐ Yes ☐ No

If **Yes**, date(s): ____________ Hospital: ____________ Lenght of stay: ____________

3. Have you ever consulted a respiratory disease specialist? ☐ Yes ☐ No

If yes, name: ____________ Address: ____________

Date: ____________ Test performed: ____________

4. Have you ever undergone respiratory tests? ☐ Yes ☐ No

If **Yes**, indicate the name of the test or tests, date, results, name of physician and/or hospital

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5. Have you ever missed work or school as a result of this respiratory problem? ☐ Yes ☐ No If **Yes**, date: ____________ Duration: ____________

6. Do you take medication? ☐ Yes ☐ No

If **Yes**: ☐ daily ☐ as required Name(s): ____________

7. Have you ever taken cortisone in tablet form? ☐ Yes ☐ No If **Yes**, date: ____________

8. Do you smoke? ☐ Yes ☐ No If **Yes**, number/day: ____________

I declare that the answers given in this document are true and complete and I agree that they form an integral part of my application for insurance.

____________	____________	____________
Date	Signature of proposed insured (signature of father, mother or legal guardian, if minor)	Signature of witness

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.