



Chronic Obstructive Pulmonary Disease (COPD)

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

State of Residence: _____

___Term 10 15 20 30 ___UL

1. What date was the proposed insured diagnosed with COPD? _____

2. Has the proposed insured ever been hospitalized for this condition? ___Yes ___No

(If yes, please provide dates): _____

3. Has a pulmonary function test ever been done? ___Yes ___No

(If yes, please provide the most recent date): _____

Results of the test: _____

4. Does the proposed insured take any medication (including oxygen and inhalers)? ___Yes ___No

(If yes, please provide the name, dosage, and frequency): _____