RESPIRATORY QUESTIONNAIRE

(To be completed by the Life to be Insured)

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health (Fiji) Limited, Level 5, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

	Full Name:		Date of Birth:	
	Proposal Number:		Dated:	

1. With regard to your chest complaint:
   a. What is the nature of these episodes?

   b. At what age did you have the first episode?

   c. What was the date of the most recent episode?

2. How frequently do these episodes occur? State number per year.

3. Do you receive treatment for these episodes? ☐ No ☐ Yes ▸ If "Yes", please state:

   a. Nature of treatment (bronchodilators, aerosol inhalants, steroid therapy).

   b. In which category mentioned below does such treatment fall?

      (i) Only occasional treatment during episodes. ☐

      (ii) Treatment over a period of month ☐

      (iii) Continuous treatment ☐

      (iv) Hospitalisation ☐

      (v) Short course of steroids ☐

4. Is your chest clear between episodes? ☐ No ☐ Yes ▸ If "No", please provide details.

5. Have you ever experienced any limitation of ability to work or been absent from work as a result of any episode?
   ☐ No ☐ Yes ▸ If "Yes", please state the number of days.

6. Have you ever had your chest x-rayed or undergone any pulmonary function tests? ☐ No ☐ Yes ▸ If "Yes", please state date and result.

	Yes	No	Date	Results
Chest X-Rayed			/ /	
Pulmonary Function Test			/ /	

Please attach copies of the above tests if available.

7.	Please state any further relevant particulars including name and address of personal medical attendant or attendants.	
	Name of Doctor:	
	Address:	

	Name of Doctor:	
	Address:	

	Name of Doctor:	
	Address:	

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: