

Mutual of Detroit

Applicant Asthma Questionnaire

Proposed Insured: _____ Policy Number: _____ Date of Birth: _____

REMARKS

- | | YES | NO | |
|---|--------------------------|--------------------------|---|
| 1) Are you currently being treated for asthma? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2) When were you first diagnosed? | | | |
| 3) When was your last treatment? Please describe. | | | |
| 4) How many episodes have you had in the past year? | | | |
| 5) Have you ever lost time from work or school? | <input type="checkbox"/> | <input type="checkbox"/> | (If "Yes" please describe) |
| 6) Have you ever: | | | |
| a. Been treated by a hospital emergency room for asthma | <input type="checkbox"/> | <input type="checkbox"/> | (If "Yes" please describe) when and where |
| b. Been hospitalized because of an asthma episode? | <input type="checkbox"/> | <input type="checkbox"/> | (If "Yes" please describe when, where and result) |
| 7) What medications are you currently taking? | | | |
| 7a) How often do you take the medications above? | | | |
| 8) If you are currently taking steroid medication, how long has it been prescribed? | | | |
| 9) Are you restricted from any kinds of activities? | <input type="checkbox"/> | <input type="checkbox"/> | (If "Yes" please describe) |
| 10) Do you smoke, or are you exposed to a smoking environment? | <input type="checkbox"/> | <input type="checkbox"/> | |

I represent that I have read and understand all the statements and answers in this questionnaire and that they are true and complete to the best of my knowledge. I agree that the statements and answers given in this questionnaire will be the basis of any insurance issued.

Proposed Insured

Agent

Date