

*The best way to show your Love*

Insured Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**RESPIRATORY QUESTIONNAIRE**

Payor/Insured that are based **abroad** or **frontliners** (local & abroad) have to answer the following questions below. This will be a requirement for approving Health Statement forms.

*Frontliners including but not limited to: HEALTHCARE WORKERS, POLICEMEN, MILITARY PERSONNEL, FIREMEN, CSR, BANK EMPLOYEES (TELLER, NEW ACCOUNTS), BRGY. WORKERS/TANODS, SECURITY GUARDS, FOOD DELIVERY CREW, GROCERY STOREKEEPERS AND PHARMACISTS.*

	YES	NO
a. History of Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. History of Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
e. X-ray showing lesions in the lungs.	<input type="checkbox"/>	<input type="checkbox"/>

*Give full details of all "Yes" answers below with dates, diagnosis, treatment and give names and addresses of all attending physicians and medical facilities. Please indicate on which letter corresponds your answers.*

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 Signature over Printed Name  
 of Insured/Payor