beneva

Questionnaire
Respiratory disorders and sleep apnea

Important: Please complete block 1 and or 2 depending on your situation and block 3 at all times.

First and last names of insured _____

Y Y Y Y M M D D
Date of birth

_____
Policy / application number

Respiratory disorder – Block 1

1. **Have you ever experienced the following respiratory disorders?** ☐ **Yes** ☐ **No**

   If yes, check the appropriate box(es):

   ☐ Asthma ☐ Chronic Bronchitis ☐ Emphysema ☐ COPD (Chronic Obstructive Pulmonary Disease)

   ☐ Other respiratory disorder, specify: _____

2. **Date of diagnosis:** Y Y Y Y M M

3. **a) How severe is your condition?**

   ☐ Mild ☐ Moderate ☐ Severe

   b) Date of last episode and/or symptoms: Y Y Y Y M M

   c) Frequency of episodes and/or symptoms: _____

4. **Do you suffer from shortness of breath, wheezing or coughing between your episodes?** ☐ **Yes** ☐ **No**

   If yes, specify symptoms and frequency: _____

5. **Have you ever undergone a chest X-ray, a pulmonary function test (spirometry), or any other respiratory or pulmonary tests?** ☐ **Yes** ☐ **No**

   If yes, complete the following table:

Name of test	Date	Result

6. **a) Have you been prescribed any medication?** ☐ **Yes** ☐ **No**

   If yes, complete the following table:

Name of medication and dosage	Frequency of use	Date of first use	Date of last use

   b) Has your medication changed in the last twelve (12) months? ☐ **Yes** ☐ **No**

   If yes, specify: _____

7. **Please indicate the name and address of the doctors and/or specialists consulted for this condition.** If none, check this box: ☐ **None**

Name	Address	Date of last consultation

8. **Have you been to the Emergency Room or been hospitalized for this condition in the last five (5) years?** ☐ **Yes** ☐ **No**

   If yes: Date: Y Y Y Y M M Duration: _____

   Date: Y Y Y Y M M Duration: _____

Respiratory disorder – Block 1 (cont.)

9. Do you have any limitations in your activities of daily living or in your leisure time due to this condition? ☐ **Yes** ☐ **No**

If yes, specify the limitations: _____

10. Have you had to take time off work due to this condition? ☐ **Yes** ☐ **No**

If yes, specify start date and duration : Date A A A A M M J J Duration: _____

Date A A A A M M J J Duration: _____

11. Additional information:

_____

_____

_____

_____

Sleep Apnea – Block 2

1. Have you been diagnosed with sleep apnea? ☐ **Yes** ☐ **No**

If yes, date of diagnosis: Y Y Y Y M M D D

2. How severe is your apnea?

☐ Mild ☐ Moderate ☐ Severe

3. What treatment have you been prescribed?

☐ Cpap/Bipap Usage: number of days per week _____ Number of hours per night _____

☐ Oral device

☐ No treatment: specify reason: _____

4. Do you have a self-monitoring application for your treatment such as MyAir, Dreammapper etc.? ☐ **Yes** ☐ **No**

If yes, verification date: Y Y Y Y M M D D

Apnea/hypopnea index (AHI) of the day: _____

Apnea/hypopnea index (AHI) for the last 30 days: _____

5. Additional information:

_____

_____

_____

_____

Declaration and signature (must be signed at all times) – Block 3

1. Declaration

I acknowledge having fully understood all of the questions above and that the answers given are true and complete. In addition, I consent to having them as an integral part of the requested insurance policy.

X _____ Y Y Y Y M M D D

Signature of insured (signature of the father, mother or legal guardian if the insured is a minor) Date of signature

Protection of personal information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the Personal Information *Protection statement* located at **beneva.ca**.