FSA
Financial Security Associates

Risk Assessment– ASTHMA

Agent Name:	
Address:	
Email:	
Phone:	
Applicant Name:	
Date Of Birth:	
Sex:	**Male** **Female**
Height/Weight:	
Occupation:	
Death Benefit:	
Type of Product:	**Term** **UL** **Whole Life** **2nd To Die**
Has Client EVER Used Tobacco? **YES** **NO**	**Date of Last Use:**
Specify All Types of Nicotine Used**:**	**Cigarettes** **Cigar** **Pipe** **Other:**
Date of First Symptoms:	
Date when last saw Doctor:	
How often does client see Doctor:	
Date of most recent breathing test:	
Does Client Use Oxygen?	**Yes** **No**

Has Client Ever Been Hospitalized for this Condition: **YES** **NO**	**List Dates of All Stays:**
Is patient currently being Treated: **YES** **NO**	**Provide Details:**
Provide Names of all Medications used:	
Is the client disabled? **YES** **NO**	**Provide Details & Date Disabled:**
Are daily activities at all limited by lungs?	**Provide Details:**

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:_____

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