

## **SLEEP APNEA QUESTIONNAIRE**

**CLIENT:** NAME \_\_\_\_\_ /  M  F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMT. REQUESTED \$ \_\_\_\_\_ / MAX. ANNUAL PREMIUM \$ \_\_\_\_\_ / TYPE OF INS.  UL  TERM YRS. LVL \_\_\_\_\_

TOBACCO USE  NO  YES, TYPE \_\_\_\_\_ / REPLACEMENT  YES  NO / CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR \_\_\_\_\_ COMPANY \_\_\_\_\_ ACTION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ / MARITAL STATUS  SINGLE  MARRIED  WIDOWED  DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLING 1 \_\_\_\_\_ SIBLING 2 \_\_\_\_\_ SIBLING 3 \_\_\_\_\_

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH \_\_\_\_\_

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS \_\_\_\_\_ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS \_\_\_\_\_

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK?  NO  YES, DETAILS \_\_\_\_\_

DATE OF LAST MEDICAL CHECKUP \_\_\_\_\_ / DATE OF LAST EKG \_\_\_\_\_ AND RESULTS \_\_\_\_\_

LAST BLOOD PRESSURE READING (RESULTS) \_\_\_\_\_ / \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE  NO  YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) \_\_\_\_\_, \_\_\_\_\_ TREATED FOR CHOLESTEROL  NO  YES

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

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| <p>1. PLEASE GIVE DATE OF DIAGNOSIS _____</p> <p>2. PLEASE NOTE TYPE DIAGNOSED:<br/><input type="checkbox"/> OBSTRUCTIVE<br/><input type="checkbox"/> CENTRAL<br/><input type="checkbox"/> MIXED</p> <p>3. HAS A SLEEP STUDY, OR STUDIES, BEEN COMPLETED?<br/><input type="checkbox"/> YES <input type="checkbox"/> NO, IF YES, PLEASE NOTE DATE(S) OF STUDY(IES):<br/>FIRST STUDY _____ LAST STUDY _____<br/>AND NOTE THE FOLLOWING:<br/>OXYGEN SATURATION LEVEL _____<br/>APNEA INDEX (AI) OR RESPIRATORY DISTURBANCE INDEX (RDI) RESULTS:<br/>_____ (NUMERIC VALUE)</p> <p>4. WHAT TREATMENT HAS BEEN PRESCRIBED (PLEASE CHECK ALL THAT APPLY):<br/><input type="checkbox"/> OBSERVATION ALONE<br/><input type="checkbox"/> WEIGHT LOSS ALONE<br/><input type="checkbox"/> CPAP MASK (IF CHECKED, DATE LAST USED) _____<br/><input type="checkbox"/> SURGERY (TRACHEOTOMY OR</p> | <p>UVULOPALATOPHARYNGOPLASTY)<br/><input type="checkbox"/> MEDICATION (PLEASE DETAIL TYPE AND DOSAGE):<br/>_____</p> <p>5. ARE THERE ANY CURRENT SYMPTOMS?<br/><input type="checkbox"/> NO <input type="checkbox"/> YES, DETAILS _____</p> <p>6. HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING ILLNESSES (CHECK ALL THAT APPLY AND GIVE DETAILS):<br/><input type="checkbox"/> ARRHYTHMIA, TYPE _____<br/><input type="checkbox"/> OTHER HEART RELATED CONDITION, TYPE _____<br/><input type="checkbox"/> ASTHMA, COPD OR EMPHYSEMA, TYPE _____<br/><input type="checkbox"/> DEPRESSION<br/><input type="checkbox"/> OVERWEIGHT, PLEASE CONFIRM HT _____ WT _____</p> <p>7. HAS THE CLIENT SMOKED CIGARETTES IN THE PAST 12 MONTHS?<br/><input type="checkbox"/> NO <input type="checkbox"/> YES, PLEASE DETAIL AMOUNT PER DAY AND DATE STOPPED, IF NO LONGER<br/>SMOKING: _____</p> <p>8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY): _____</p> |
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Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.