

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:
<input type="checkbox"/> OBSTRUCTIVE
<input type="checkbox"/> CENTRAL
<input type="checkbox"/> MIXED</p> <p>3. HAS A SLEEP STUDY, OR STUDIES, BEEN COMPLETED?
<input type="checkbox"/> YES <input type="checkbox"/> NO, IF YES, PLEASE NOTE DATE(S) OF STUDY(IES):
FIRST STUDY _____ LAST STUDY _____
AND NOTE THE FOLLOWING:
OXYGEN SATURATION LEVEL _____
APNEA INDEX (AI) OR RESPIRATORY DISTURBANCE INDEX (RDI) RESULTS:
_____ (NUMERIC VALUE)</p> <p>4. WHAT TREATMENT HAS BEEN PRESCRIBED (PLEASE CHECK ALL THAT APPLY):
<input type="checkbox"/> OBSERVATION ALONE
<input type="checkbox"/> WEIGHT LOSS ALONE
<input type="checkbox"/> CPAP MASK (IF CHECKED, DATE LAST USED) _____
<input type="checkbox"/> SURGERY (TRACHEOTOMY OR</p> | <p>UVULOPALATOPHARYNGOPLASTY)
<input type="checkbox"/> MEDICATION (PLEASE DETAIL TYPE AND DOSAGE):
_____</p> <p>5. ARE THERE ANY CURRENT SYMPTOMS?
<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):
<input type="checkbox"/> ARRHYTHMIA, TYPE _____
<input type="checkbox"/> OTHER HEART RELATED CONDITION, TYPE _____
<input type="checkbox"/> ASTHMA, COPD OR EMPHYSEMA, TYPE _____
<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> OVERWEIGHT, PLEASE CONFIRM HT _____ WT _____</p> <p>7. HAS THE CLIENT SMOKED CIGARETTES IN THE PAST 12 MONTHS?
<input type="checkbox"/> NO <input type="checkbox"/> YES, PLEASE DETAIL AMOUNT PER DAY AND DATE STOPPED, IF NO LONGER
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.