SLEEP APNEA QUESTIONNAIRE

Agent:	Phone:	Fax:

Proposed Insured Name: _____ ☐ M ☐ F Date of Birth: _____
Face amount: _____ Max. Premium: $_____/year ☐ UL ☐ WL ☐ Term ☐ Survivorship
Do you currently smoke cigarettes? ☐ Yes ☐ No If no, did you ever smoke? ☐ Never ☐ Quit (Date): _____
Do you currentl use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...)? ☐ Yes ☐ No
If yes, please provide details: _____
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

1. Please provide date of diagnosis: _____

2. Has the Sleep Apnea been dianosed as:

☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

3. Has the severity of the Sleep Apnea been:

☐ Stable ☐ Increasing ☐ Decreasing ☐ Flunctuating up and down ☐ Unknown

4. Has an overnight sleep study (Polysomnogram) been done?

☐ No ☐ Yes, date: _____

What was the Sleep Apnea Index: _____ What was the oxygen saturation? _____%

5. How is the Sleep Apnea being treated?

☐ No treatment ☐ Medicated ☐ Weight Loss ☐ CPAP Mask
☐ Surgery (UPPP) ☐ Surgery (Tracheotomy) ☐ Other: _____

6. Does the proposed insured have any of the following? If yes, provide details under item (9) below:

☐ Overweight ☐ Arrythmia ☐ Coronary Artery Disease
☐ Stroke ☐ Depression ☐ Lung Disease

Other: _____

7. Does the proposed insured use any alcohol? If yes, please describe usage: _____

_____

8. Does the proposed insured use any medications for any reason?

Name of Medication (Prescribed or OTC)	Dates Used	Quantity	Frequency

9. Please advise of any additional information that may help us determine a likely rating: _____

_____

_____

_____

_____

_____

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