

## 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?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_  
 Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

(1) Please provide date of diagnosis: \_\_\_\_\_

(2) Has the Sleep Apnea been diagnosed as:

- Obstructive  Central  Mixed  Unknown

(3) Has the severity of the Sleep Apnea been:

- Stable  Increasing  Decreasing  Fluctuating 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  Arrhythmia  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 (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

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

\_\_\_\_\_  
 \_\_\_\_\_

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