

Underwriting Questionnaire

Sleep Apnea



Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

Male Female Face Amount _____ Max Premium \$ _____ /yr.

Term Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? Yes No

Frequency _____ Date of last use _____ Type _____

Date of diagnosis _____ Diagnosed as Obstructive Central Mixed Unknown

Severity Severe Moderate Mild

Has an overnight sleep study been done Yes No

If yes, provide sleep index AHI _____ RDI _____ Lowest oxygen saturation _____%

How is the sleep apnea being treated

No treatment Medicated Weight loss CPAP Mask
 Surgery (UPPP) Surgery (tracheotomy) Other _____

Does the client have any of the following (if yes, provide details below)

Overweight Arrhythmia Coronary Artery Disease Stroke Depression Lung Disease

Does the client use alcohol Yes No (if yes, describe usage below)

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: