## **Underwriting Questionnaire**

## **Sleep Apnea**

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Producer Name	Pn	Phone Date Date of Birth		e		
Client Name	Da					
☐ Male ☐ Female	Face Amount	Max Premium \$		/yr.		
☐ Term ☐ Permanent	Has the client ever used ar	ny form of tobacco (cig	garettes, cigars, p	ipe, snuff, etc.)? [	□Yes □No	
Frequency	Date of	last use		Type		
Date of diagnosis	Diagnosed a	s	□Central	□Mixed	□Unknown	
Severity Severe	☐Moderate ☐Mi	ld				
Has an overnight sleep study If yes, provide sleep index	/ been done	Lowest oxygen	saturation	_%		
How is the sleep apnea bein ☐No treatment ☐Surgery (UPPP)			□CPA			_
	the following (if yes, provide de Arrhythmia □Coronary Ar		□Stroke	☐ Depression	□Lung Disease	
Does the client use alcohol	☐Yes ☐No (if yes, desc	cribe usage below)				
Name of Medication (s	prescription or otherwise)	Dates Used	Quar	itity Taken	Frequency Taken	
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List any other major health problems the client has:



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