

SLEEP APNEA

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____

Type of Coverage: Term UL Survivor **Type of Coverage:** Term UL Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis: _____

2. Was the sleep apnea diagnosed as:

Obstructive Central Mixed Unknown

3. How is the sleep apnea being treated?

Observation alone

Weight loss

CPAP mask; if CPAP given, date use was terminated: _____

Surgery; Date of surgery: _____

Other; please give details _____

4. If surgery was done, was sleep apnea corrected? No Yes; please give details

5. Has client had any of the following?

lung disease overweight chest pain or coronary artery disease

depression stroke arrhythmia

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required) No Yes; please give details
