Sleep Apnea Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured diagnosed with Sleep Apnea? _____

2. What type of Sleep Apnea was diagnosed?

   ___ Obstructive ___ Central ___ Mixed ___ Unknown

3. Has the severity of the Sleep Apnea been diagnosed as:

   ___ Stable ___ Increasing ___ Decreasing ___ Fluctuating up and down ___ Unknown

4. Has an overnight sleep study (Polysomnogram) been done? ___ Yes ___ No
   If yes, date of study? _____
   What was the Sleep Apnea Index? _____
   What was the oxygen saturation? _____%

5. How is the Sleep Apnea being treated?

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

6. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

   ___ Overweight ___ Depression ___ Arrhythmia
   ___ Lung Disease ___ Coronary Artery Disease ___ Stroke
   ___ Other: _____

7. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) _____
   _____
   _____

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