Sleep Apnea Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:					
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**	
Occupation & Length of Employment:					
Tobacco Use	Never Used	Totally Stopped		Current User	
		Date Stopped		**Type Used**	
Type of Coverage	Term	UL	Survivor	**Amount $**	

Essential Information

1	Date of first Diagnosis		Was the sleep apnea diagnosed as:	☐ obstructive	☐ mixed
				☐ central	☐ unknown
2	How is the sleep apnea being treated	☐ observation alone	☐ weight loss	☐ surgery Date of Surgery________	
		☐ CPAP mask; if CPAP given, date use was terminated			
		☐ Other, please give details:			
3	If surgery was done, or there was other method of treatment – give full details (dates and outcome)				
4	Was Sleep Apnea corrected??	☐ Yes	☐ No		
5	Has client had any of the following	☐ lung disease	☐ stroke		
		☐ overweight	☐ arrhythmia		
		☐ depression	☐ chest pain or coronary artery disease		
6	List current medications (accurate name, dosage and reason)				
7	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:		

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