

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 Disability **Coverage Amount:** _____
Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____
Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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: _____ AHI at diagnosis if known: _____
 Obstructive Central Mixed Unknown AHI on follow up sleep study if follow up completed: _____

3. How is the sleep apnea being treated?
 Observation alone If AHI unknown, please provide severity as reported by your doctor:
 Weight loss _____ Mild _____ Moderate _____ Severe _____ Unknown
 CPAP mask; if CPAP given, date use was terminated: _____ Date CPAP was started: _____
 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

