Underwriting Questionnaire | Sleep Apnea

Underwriting

Financial Professional Information

Name:_____ Phone: _____ Date: _____

Client Information

Name:_____ Date of Birth: _____ State of Residence:_____

☐ Male ☐ Female Height:_____ft._____in. Weight:_____lbs.

Face Amount:_____ Max Premium $_____/yr.

Desired Life Insurance Type: ☐ Term ☐ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency:_____ Date of Last Use:_____ Type:_____

Date of diagnosis_____ Diagnosed as ☐Obstructive ☐Central ☐Mixed ☐Unknown
Severity ☐Severe ☐Moderate ☐Mild
Has an overnight sleep study been done ☐Yes ☐No
If yes, provide sleep index AHI_____ RDI_____ Lowest oxygen saturation_____%

How is the sleep apnea being treated
☐No treatment ☐Medicated ☐Weight loss ☐CPAP Mask
☐Surgery (UPPP) ☐Surgery (tracheotomy) ☐Other

Does the client have any of the following (if yes, provide details below)
☐Overweight ☐Arrhythmia ☐Coronary Artery Disease ☐Stroke ☐Depression ☐Lung Disease

Does the client use alcohol ☐Yes ☐No (if yes, describe usage below)

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has:

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