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Sleep Apnea Questionnaire

Name Male Female Age _____ Date of Birth _____

Tobacco Use No Cigarettes Other tobacco _____ Date quit? _____

State _____ Amount of Insurance _____ Type of Insurance _____

Occupation/Source of income: _____

Sleep Apnea

1. Type: Central Obstructive or Mixed _____ Date Sleep Apnea diagnosed: _____

2. Sleep study completed? _____ Date of first sleep study: _____

3. Test Results. Oxygen saturation level: _____ Apnea Index results: _____

4. Treatment? Weight loss Use CPAP (Continuous Positive Airway Pressure mask)

Medication: protriptyline progesterone acetazolamide other:

5. Surgery: tracheotomy uvulopalatopharyngoplasty Date: _____

6. Any current symptoms Yes No -Details: _____

7. Cardiac Arrhythmias Yes No - Details: _____

8. Asthma, COPD or Emphysema Yes No – Details: _____

General Questions:

1. Do you have any other major health problems? No Yes – Details: _____

2. List all medications: _____

3. Height _____ Weight _____ Most recent blood pressure reading: _____

Agent Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance Copyright 2000 to 2004. By Fredric Berger. All rights reserved.