



Agent: _____ Phone: _____ Fax: _____
 Proposed Insured Name: _____ M F Date of birth: _____
 Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____
 Height: ____ ft. ____ in. Weight: _____ lbs.

(1) Please provide date of diagnosis: _____

(2) Has the Sleep Apnea been diagnosed as:

Obstructive Central Mixed Unknown

(3) Has the severity of the Sleep Apnea been:

Stable Increasing Decreasing Fluctuating up and down Unknown

(4) Has an overnight sleep study (Polysomnogram) been done?

No Yes, date: _____ What was the Sleep Apnea Index: _____ What was the oxygen saturation? _____%

(5) How is the Sleep Apnea being treated?

No treatment Medicated Weight Loss CPAP Mask
 Surgery (UPPP) Surgery (tracheotomy) Other: _____

(6) Does the proposed insured have any of the following? If yes, provide details under item (9) below:

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

(7) Does the proposed insured use any alcohol? If yes, please describe usage: _____

(8) Does the proposed insured use any medications for any reason?

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(9) Please advise of any additional information that may help us determine a likely rating:

