EMG
Insurance Brokerage

SLEEP APNEA QUESTIONNAIRE

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 t he 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:

_____

_____