© QUICK QUOTE FOR SLEEP APNEA

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

CLIENT: NAME _____ / [ ] M [ ] F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMNT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS.: [ ] PERM [ ] TERM YRS. LEVEL _____

TOBACCO USE: [ ] NO [ ] YES, DETAIL _____ / REPLACEMENT? [ ] YES [ ] NO / CURRENT ANN. PREMIUM $ _____

LAST LIFE INSURANCE APP.: YEAR _____ COMPANY _____ ACTION _____

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

FOR USE BY CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. PLEASE GIVE DATE OF DIAGNOSIS _____

2. PLEASE NOTE TYPE DIAGNOSED:

[ ] OBSTRUCTIVE
[ ] CENTRAL
[ ] MIXED

3. HAS A SLEEP STUDY, OR STUDIES, BEEN COMPLETED?

[ ] YES [ ] NO IF YES, PLEASE NOTE DATE(S) OF STUDY(IES):

FIRST STUDY _____ LAST STUDY _____

AND NOTE THE FOLLOWING:

OXYGEN SATURATION LEVEL _____

APNEA INDEX RESULTS _____

4. WHAT TREATMENT AHS BEEN PRESCRIBED (PLEASE CHECK ALL THAT APPLY):

[ ] OBSERVATION ALONE

[ ] WEIGHT LOSS ALONE

[ ] CPAP (CONTINUOUS POSITIVE AIRWAY PRESSURE) MASK

IF CHECKED, DATE LAST USED _____

[ ] SURGERY – TRACHEOTOMY OR UVULOPALATOPHARYNGOPLASTY

[ ] MEDICATION IF CHECKED, PLEASE DETAIL TYPE AND DOSAGE:

_____

5. ARE THERE ANY CURRENT SYMPTOMS?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

6. HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING LLNESSES (CHECK ALL THAT APPLY, AND GIVE DETAILS):

[ ] ARRHYTHMIA, TYPE _____

[ ] OTHER HEART RELATED CONDITION, TYPE _____

[ ] ASTHMA, COPD OR EMPHYSEMA, TYPE _____

[ ] DEPRESSION

[ ] OVERWEIGHT, PLEASE CONFIRM HEIGHT AND WEIGHT _____

7. HAS THE CLIENT SMOKED CIGARETTES IN THE PAST 12 MONTHS?

[ ] YES [ ] NO IF YES, PLEASE DETAIL AMOUNT PER DAY AND DATE STOPPED, IF NO LONGER SMOKING:

_____

8. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

_____

9. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

10. CLIENT'S OCCUPATION _____

11. PLEASE LIST ANY OTHER ILLNESSES OR IMPAIRMENTS; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

_____

_____

_____

_____