



**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

**FAMILY HISTORY**

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
***If yes, use separate sheet to provide this information, including age of onset and date of death***

**PROPOSED INSURED'S EXISTING INSURANCE**

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis: \_\_\_\_\_

2. Was the sleep apnea diagnosed as:

Obstructive  Central  Mixed  Unknown

3. How is the sleep apnea being treated?

Observation alone

Weight loss

CPAP mask; if CPAP given, date use was terminated: \_\_\_\_\_

Surgery; Date of surgery: \_\_\_\_\_

Other; please give details \_\_\_\_\_

4. If surgery was done, was sleep apnea corrected?  No  Yes; please give details

5. Has client had any of the following?

lung disease  overweight  chest pain or coronary artery disease

depression  stroke  arrhythmia

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details