QUICK QUOTE FOR SLEEP APNEA

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative 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 _____

AMT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ❑ UL ❑ TERM YRS. LVL _____

TOBACCO USE ❑ NO ❑ YES, TYPE _____ / REPLACEMENT? ❑ YES ❑ NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

FAMILY HISTORY: AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, GIVE RELATION(S), AGE(S) AND CAUSE(S) _____

DRIVING RECORD: # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK ❑ NO ❑ YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____/_____ / ARE YOU TREATED FOR BLOOD PRESSURE ❑ NO ❑ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL ❑ NO ❑ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

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(AI) OR RESPIRATORY DISTURBANCE INDEX(RDI) RESULTS _____(Numeric value)

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, PLEASE DETAIL TYPE AND DOSAGE:

_____

_____

5. ARE THERE ANY CURRENT SYMPTOMS?

❑ NO ❑ 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

HEIGHT _____ / WEIGHT _____

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

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

_____

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

_____

_____