

# Life Scan Questionnaire for **SLEEP APNEA**

## LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For \_\_\_\_\_ [ ] Male [ ] Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ [ ] **Non Smoker** [ ] **Smoker**

Have you ever used tobacco? [ ] Yes [ ] No If yes, state month and year of last use of any tobacco product: \_\_\_\_\_

Type of tobacco used: [ ] Cigarettes [ ] Cigars [ ] Chews [ ] Pipe  
Amt\$ \_\_\_\_\_ Type: [ ] Whole Life or Universal [ ] Term

Last application for life insurance: Year \_\_\_\_\_ Company \_\_\_\_\_

Result: [ ] Preferred [ ] Standard [ ] Rated/Rating \_\_\_\_\_ [ ] Declined

[ ] **Life Insurance Risk Evaluation and Market Search for Best Offer**

[ ] **Risk Evaluation Only**

1. When was Sleep Apnea diagnosed?

Month \_\_\_\_\_ Year \_\_\_\_\_

2. Please note type of sleep apnea diagnosed:

[ ] Obstructive

[ ] Central

[ ] Mixed

3. Has a sleep study or studies been completed?

[ ] Yes [ ] No

If yes, please note month/year

First Study Month \_\_\_\_\_ Year \_\_\_\_\_

Second Study Month \_\_\_\_\_ Year \_\_\_\_\_

4. What treatment was prescribed?

[ ] Observation Alone

[ ] Weight Loss Alone

[ ] CPAP Mask (Continuous Positive Air Pressure)

If checked, date last used Month \_\_\_\_\_ Year \_\_\_\_\_

[ ] Surgery Month \_\_\_\_\_ Year \_\_\_\_\_

[ ] Medication Type & Dosage \_\_\_\_\_

5. Are there any current symptoms?

[ ] Yes, If Yes, please explain below.

[ ] No

Life Factors

**Date of last stress EKG**

Month \_\_\_\_ Year \_\_\_\_ [ ] Never

**Family History**, has either parent or any sibling died before age 65?

[ ] Yes [ ] No If yes, please list cause and age.

**Blood Pressure**, with or without medication \_\_\_\_\_ / \_\_\_\_\_

List medication, if any \_\_\_\_\_

Result of last **Cholesterol** test, if known \_\_\_\_\_

List all **Other Illnesses** not listed on this page.

List all medications currently being used except those previously listed.  
(name, dosage and times per day)

Agent Information

Name \_\_\_\_\_

Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_

ST \_\_\_\_ Zip \_\_\_\_ email \_\_\_\_\_



Insurance Services  
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Salt Lake City UT 84171  
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Toll Free 888-888-7441 Fax 888-888-7449  
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This is not an application for life insurance. The information contained herein will be used solely for the purpose of assessing which insurance carriers are likely to respond most favorably to the risk situation as stated above. The questions and answers listed will be used in the evaluation of the person listed above. All quotes are tentative, and are subject to the submitted medical evidence and other criteria used in the underwriting of life insurance.

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