financial life insurance

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SLEEP APNEA QUESTIONNAIRE

TO BE COMPLETED BY THE PROPOSED INSURED

Name of Proposed Insured: _____ DOB: _____
MM/DD/YYYY

1) What date was sleep apnea diagnosed by a member of the medical profession? _____

2) Did you have a sleep study? ☐ No ☐ Yes If yes, please provide dates of sleep study(ies):

_____

_____

3) Results of sleep study? *Check one*

☐ Mild ☐ Moderate ☐ Severe ☐ Unknown and/or Apnea Index _____

4) What is the treatment? *Check all that apply*

☐ Surgery ☐ Weight Loss ☐ Medication ☐ CPAP Machine ☐ No Treatment

5) List all medications currently taken, provide dosage and frequency:

_____

_____

6) Are you compliant with treatment? ☐ No ☐ Yes

7) Is the treatment effective? ☐ No ☐ Yes If use CPAP, how often is it used?_____

8) Have your symptoms: ☐ Improved ☐ Stayed the Same ☐ Worsened

9) Have you ever been diagnosed or treated or received medical advice by a member of the medical profession with issues such as: *Check all that apply*

☐ Hypertension ☐ Irregular Heartbeat ☐ Heart Disease ☐ Diabetes
☐ Obesity ☐ Memory Loss ☐ Driving Concerns

10) List the doctor or medical facility that has the most up-to-date information concerning your sleep apnea; provide name, address, and date last seen:

_____

_____

_____

11) Please provide any additional details that could help us understand your disease:

_____

_____

_____

I understand that this declaration will be relied upon by the 1891 Financial Life Insurance in determining my insurability. I understand that any material misstatement in this declaration, or elsewhere, could render the policy, if issued, voidable. I declare that the above answers are true and complete to the best of my knowledge and belief.

_____ _____
Signature of Proposed Insured Date

If age 16 or over, or Parent or Guardian if under age 16 or the age of majority required by the state where the policy is issued for delivery