BROOKFIELD PARTNERS

Sleep Apnea Questionnaire

UNDERWRITING QUESTIONNAIRE

AGENT & CASE INFORMATION

AGENT NAME | PHONE | E-MAIL

PROPOSED INSURED

CLIENT NAME | DATE OF BIRTH | STATE

HEIGHT | WEIGHT | FACE AMOUNT

Sex: ☐ Male ☐ Female

Tobacco / Nicotine Use: ☐ Yes ☐ No

COVERAGE REQUESTED

Type of Insurance: ☐ Universal Life ☐ Whole Life ☐ Survivorship

☐ Term — number of years:

QUESTIONNAIRE

1. When was the proposed insured diagnosed with Sleep Apnea?

2. What type of Sleep Apnea was diagnosed?

☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

3. Has the severity of the Sleep Apnea been diagnosed as:

☐ Stable ☐ Increasing ☐ Decreasing ☐ Fluctuating up and down ☐ Unknown

4. Has an overnight sleep study (Polysomnogram) been done? ☐ Yes ☐ No

If yes, date of study? §

What was the Sleep Apnea Index? §

What was the oxygen saturation? §%

5. How is the Sleep Apnea being treated?

☐ No treatment ☐ Surgery (UPPP) ☐ Medicated

- ☐ Surgery (tracheotomy)
- ☐ Weight loss
- ☐ CPAP Mask (setting: _____)
- ☐ Other _____

6. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

- ☐ Overweight ☐ Depression ☐ Arrhythmia
- ☐ Lung Disease ☐ Coronary Artery Disease ☐ Stroke
- ☐ Other _____

7. Is the proposed insured currently taking any medication(s)? ☐ Yes ☐ No

If yes, provide name, dosage and frequency of medication(s)

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