Underwriting Questionnaire
Sleep Apnea

Truist Life Insurance Services

Producer Name_____ Phone _____ Date _____

Client Name _____ Date of Birth _____

☐ Male ☐ Female Face Amount _____ Max Premium $ _____/yr.

☐ Term ☐ Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency_____ Date of last use _____ Type _____

Date of diagnosis _____ Diagnosed as ☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

Severity ☐ Severe ☐ Moderate ☐ Mild Client height _____ft _____in Client weight _____ lbs

Has an overnight sleep study been done ☐ Yes ☐ No
If yes, provide sleep index AHI _____ RDI_____ Lowest oxygen saturation _____%

How is the sleep apnea being treated
☐ No treatment ☐ Medicated ☐ Weight loss ☐ CPAP Mask
☐ Surgery (UPPP) ☐ Surgery (tracheotomy) ☐ Other_____

Does the client have any of the following (if yes, provide details below)
☐ Overweight ☐ Arrhythmia ☐ Coronary Artery Disease ☐ Stroke ☐ Depression ☐ Lung Disease

Does the client use alcohol ☐ Yes ☐ No (if yes, describe usage below)

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: