AGENTS INSURANCE SERVICES of AMERICA, Inc.
Email: to UndSolutions@cs.com or Fax to: (760) 435 9703
Telephone: (760) 435 9702

Sleep Apnea Questionnaire

Name [] Male [] Female Age Date of Birth

Tobacco Use [] No [] Cigarettes [] Other tobacco Date quit?

State Amount of Insurance Type of Insurance

Occupation/Source of income:

Sleep Apnea

1. Type: [] Central [] Obstructive or Mixed Date Sleep Apnea diagnosed:

2. Sleep study completed? Date of first sleep study:

3. Test Results. Oxygen saturation level: Apnea Index results:

4. Treatment? [] Weight loss [] Use CPAP (Continuous Positive Airway Pressure mask)

[] Medication: [] protriptyline [] progesterone [] acetazolamide [] other:

5. Surgery: [] tracheotomy [] uvulopalatopharyngoplasy Date:

6. Any current symptoms [] Yes [] No -Details:

7. Cardiac Arrhythmias [] Yes [] No - Details:

8. Asthma, COPD or Emphysema [] Yes [] No – Details:

General Questions:

1. Do you have any other major health problems? [] No [] Yes – Details:

2. List all medications:

3. Height Weight Most recent blood pressure reading:

Agent Name:

Address: **City:** **State:** **Zip:**

Phone: **Fax:** **Email:**

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance Copyright 2000 to 2013. By Fredric Berger. All rights reserved.