Blue text on a black background

Description automatically generated with medium confidence**SLEEP APNEA QUESTIONNAIRE –APPLICANT**

(This questionnaire will form part of the application)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | **Last Name:** |  | |
| **Date of Birth** (mm/dd/yyyy): | |  | **Policy/Application No.:** | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. When were you first diagnosed with sleep apnea? | | | |  | | |
| 1. What was the severity level of sleep apnea at diagnosis? | | | | | | |
| Mild (AI/AHI Index ≤ 20) | | | | Moderate (AI/AHI Index 21-30) | | |
| Severe (AI/AHI Index 31-40) | | | | Extreme (AI/AHI Index > 40) | | |
| 1. What is your current treatment or which treatment was given? | | | | | | |
| Type of Treatment | | Date (Month/Year) | | | | |
| CPAP machine | |  | | | | |
| Oral splint | |  | | | | |
| Surgery | |  | | | | |
| Others: | |  | | | | |
| 1. Are you symptom-free in terms of your condition (e.g., free of daytime sleepiness, snoring, morning headaches, fatigue, tiredness, memory problems)? | | | | | | |
| If Yes, since when? (Please provide details.) | | | No | | | |
|  | | | | | | |
| 1. Have you ever received a follow-up sleep study? | | | | | | |
| Yes (Please provide the date and answer 5.1.) | | | | | No | |
|  | | | | | | |
| 5.1 What severity level did the sleep study diagnose? | | | | | | |
| Mild (AI/AHI Index ≤ 20) | | | | Moderate (AI/AHI Index 21-30) | | |
| Severe (AI/AHI Index 31-40) | | | | Extreme (AI/AHI Index > 40) | | |
| 1. Please provide any additional information that you feel is important. | | | | | | |
|  | | | | | | |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition: | | | | | | |
| Name of Doctor, Hospital or Clinic | Address | | | | | Date of Last Consultation (Month/Year) |
|  |  | | | | |  |
|  |  | | | | |  |

|  |
| --- |
| **DECLARATION** |
|  |
| **I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.**  **I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.** |

|  |  |
| --- | --- |
| **Name:** |  |

|  |  |
| --- | --- |
| **Signature:** |  |

|  |  |
| --- | --- |
| **Date of Signing:** |  |

A picture containing text, screenshot, black, font

Description automatically generatedA picture containing text, font, screenshot, black

Description automatically generated