**SLEEP APNEA QUESTIONNAIRE –APPLICANT**

(This questionnaire will form part of the application)

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

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| 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.
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|       |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition:
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| Name of Doctor, Hospital or Clinic | Address | Date of Last Consultation (Month/Year) |
|       |       |       |
|       |       |       |

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| **DECLARATION** |
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| **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.**  |

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| --- | --- |
| **Name:** |       |

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| **Signature:** |  |

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

