DIVERSIFIED™
INDIVIDUAL BROKERAGE LLC
Go ahead.

PRINT SUBMIT

QUICK QUOTE FOR SLEEP APNEA

CLIENT: NAME _____ / ☐M ☐F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ☐UL ☐TERM YRS. LVL _____

TOBACCO USE ☐NO ☐YES, TYPE _____ / REPLACEMENT ☐YES ☐NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED

FAMILY HISTORY –
AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH _____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET_____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? ☐NO ☐YES, DETAILS_ _____

DATE OF LAST MEDICAL CHECKUP _____ RESULTS _____

DATE OF LAST RESTING EKG _____ RESULTS_____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____/ ARE YOU TREATED FOR BLOOD PRESSURE? ☐NO ☐YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____/ARE YOU TREATED FOR CHOLESTEROL? ☐NO ☐YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

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1. PLEASE GIVE DATE OF DIAGNOSIS _____

2. PLEASE NOTE TYPE OF SLEEP APNEA:
☐OBSTRUCTIVE
☐CENTRAL
☐MIXED

3. HAS A SLEEP STUDY, OR STUDIES, BEEN COMPLETED?

☐YES ☐NO, IF YES, PLEASE NOTE DATE(S) OF STUDY(IES):

FIRST STUDY _____ LAST STUDY _____

PLEASE NOTE THE FOLLOWING RE: SLEEP STUDY:

LOWEST OXYGEN SATURATION LEVEL_____

APNEA INDEX (AI) AND RESPIRATORY DISTURBANCE INDEX (RDI) RESULTS:

AI = _____ RDI = _____ (NUMERIC VALUES)

4. WHAT TREATMENT HAS BEEN PRESCRIBED (PLEASE CHECK ALL THAT APPLY):

☐OBSERVATION ALONE
☐WEIGHT LOSS ALONE
☐CPAP MASK: IF CHECKED, DATE LAST USED _____
☐SURGERY; IF CHECKED, PLEASE PROVIDE TYPE AND DATE OF SURGERY:_____
☐MEDICATION (PLEASE DETAIL TYPE AND DOSAGE):_____
_____

5. ARE THERE ANY CURRENT SYMPTOMS?

☐NO ☐YES, DETAILS _____

6. HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING ILLNESSES (CHECK ALL THAT APPLY AND GIVE DETAILS):

☐ARRHYTHMIA, TYPE _____

☐OTHER HEART RELATED CONDITION, TYPE _____

☐ASTHMA, COPD OR EMPHYSEMA, TYPE _____

☐DEPRESSION

☐OVERWEIGHT; PLEASE CONFIRM HT _____ WT _____

7. HAS THE CLIENT SMOKED CIGARETTES IN THE PAST 12 MONTHS? ☐NO ☐YES; PLEASE DETAIL AMOUNT PER DAY AND DATE STOPPED, IF NO LONGER SMOKING:

_____

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS AND VITAMINS TAKEN:

_____

_____

_____

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