

**Obstructive Sleep Apnea -
Ask "Rx" -pert Underwriter (*ask our experts*)**

Producer _____ Phone _____ Fax _____
Client _____ Age/DOB _____ Sex _____

If your client has sleep apnea, please answer the following:

1. Please list date of diagnosis: _____
2. Please note date of most recent sleep study and attach a copy of the report. _____ (date)
3. Was the sleep apnea diagnosed as:
 - Obstructive
 - Central
 - Unknown
4. How is the sleep apnea being treated?
 - Observation alone Weight loss Other
 - C PAP/BiPAP mask Surgery
 - Please give details _____
5. Is your client on any medications?
 - Yes, please give details _____
 - No
6. What is your client's weight and blood pressure? _____
7. Please check if your client has had any of the following:
 - Lung disease Accidents such as motor vehicle accidents
 - Heart disease Arrhythmia
 - Stroke Depression
8. Has your client smoked cigarettes in the last 12 months?
 - Yes, please give details _____
 - No
9. Does your client have any other major health problems (*ex: cancer, etc.*)?
 - Yes, please give details _____
 - No

After reading the Rx for Success on Obstructive Sleep Apnea, please feel free to use the Ask "Rx" -pert Underwriter for an informal quote.

*This material is intended for insurance informational purposes only and is not personal medical advice for clients.
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