APPLICATION NUMBER

SLEEP APNEA QUESTIONNAIRE
AMERICAN INCOME LIFE INSURANCE COMPANY
PO BOX 2608
WACO, TX 76797

PLEASE INDICATE APPROPRIATE APPLICANT'S NAME IN SHADED AREA

NAME _____

1. Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No
2. Have you ever participated in a sleep study? ☐ Yes ☐ No

   If YES, were the results ☐ normal or ☐ abnormal?

   Name, address and phone number of facility where study was conducted: _____

   _____
3. Was a C-PAP machine or any type of medical treatment or surgery recommended? ☐ Yes ☐ No

   If YES, what was recommended? _____
4. If a C-PAP was recommended, do you use the C-PAP machine? ☐ Yes ☐ No
5. If medical treatment was recommended, did you follow through with the treatment? ☐ Yes ☐ No
6. Have you ever had surgery for sleep apnea? ☐ Yes ☐ No Date of Procedure: _____

   Name, address and phone number of physician and/or hospital: _____

   _____
7. Name, address and phone number of physician with current records: _____

   _____

X _____ _____ X _____ _____

Signature of Applicant Date Signature of Agent Date