HUMANIA ASSURANCE MD®

# Sleep Apnea Questionnaire

## Identification

Policy number:

Name of person to be insured:

First Name of person to be insured:

Date of birth: year / month / day

## Sleep Apnea Section

1. Have you completed a sleep study? ☐ Yes ☐ No

   IF YES: Were you diagnosed with sleep apnea and what was the date of diagnosis?

   IF NO: Were you advised or recommended to have a sleep study that has yet to be completed? ☐ Yes ☐ No

      IF YES: When is it scheduled to be completed?

2. Have you been told your sleep apnea is: ☐ Mild ☐ Moderate ☐ Severe

3. Do you need treatment for your condition?

   IF YES: Please confirm what type of treatment such as a CPAP(Continuous Positive Airway Therapy) machine or other?

4. Are you compliant with the treatment? ☐ Yes ☐ No

5. How many days per week are using your treatment?

6. Are there any complications due to your sleep apnea? ☐ Yes ☐ No

   IF YES, please provide details:



4100-523-en
2021/02

## Sleep Apnea Section (cont.)

I, the undersigned, declare that the information provided above is complete and accurate and shall form the basis of the contract with Humania Assurance.

Signed at: _____ on: _____ / _____ / _____
year / month / day

Signature of witness _____

Signature of proposed insured _____

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6



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