Berkshire Advisor Resource, Inc.

Questionnaire: Back History

Please complete the following questions with as many details as possible. In this application supplement, "you" and "your" mean the Proposed Insured.

This application supplement is part of application(s) for insurance on: _____
Proposed Insured (please print)

1. In the last 10 years, have you had any symptoms, complaints, disorders, medical consultations or treatments concerning any of the following regions of the back? If you answer yes, insert dates of first and last symptoms.

Upper (neck/cervical region) ☐ Yes ☐ No Dates: _____

Middle (thoracic region) ☐ Yes ☐ No Dates: _____

Lower (lumbosacral region) ☐ Yes ☐ No _____

2. Describe your symptoms and reasons for medical consultations: _____

_____

_____

3. Name and address of physicians, chiropractors, or other therapists and month/year each was last seen:

_____

_____

4. Have you ever had surgery for any of these conditions: ☐ Yes ☐ No

If yes, give dates, reasons and name and address of hospital or facility: _____

_____

5. Describe other type(s) of treatment received (manipulation, heat, physical therapy): _____

_____

_____

6. Has treatment included the use of prescription medications: ☐ Yes ☐ No List medications and start/stop dates:

_____

7. Name prescribing physician (include address) if not shown in item 3 above: _____

8. Have you missed work more than 4 consecutive work days for any of the above conditions? ☐ Yes ☐ No

If yes, give dates and details: _____

Signature of Proposed Insured: _____ Date: _____

Berkshire Advisor Resource, Inc.

Questionnaire: Sleep Apnea

This application supplement is part of application(s) for insurance on: _____
Proposed Insured (please print)

1. Date of diagnosis: _____

2. The sleep apnea was diagnosed as: ☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

3. Date of last sleep study: _____

(Please attach a copy of the report)

4. How is the sleep apnea being treated? ☐ Observation alone ☐ Weight loss ☐ Surgery

☐ CPAP mask ☐ Other: _____

5. Has surgery been performed? Dates and results, and date of follow up sleep study: _____

_____

_____

6. Do you use a CPAP regularly? How long? _____

7. Please list any medications you are taking and the dosage: _____

_____

8. Do you have a history of: ☐ Lung disease ☐ Chest Pain or coronary artery disease

☐ Depression ☐ Overweight ☐ Arrhythmia ☐ Stroke ☐ Cancer

Comments or other major health problem which should be noted: _____

_____

_____

_____

9. Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No

Signature of Proposed Insured: _____ Date: _____