DIABETES MELLITUS QUESTIONNAIRE

Agent: Phone: Fax:

Proposed Insured Name: _____ ❒ M ❒ F Date of Birth: _____
Face Amount: _____ Max. Premium: $_____/year ❒ UL ❒ WL ❒ Term ❒ Survivorship
Do you currently smoke cigarettes? ❒ Y ❒ N If no, did you ever smoke: ❒ Never ❒ Quit (Date): _____
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): ❒ Y ❒ N
If Yes, please provide details:_____
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____
Height: ____ft. ____in. Weight: ____lbs.

(1) Date of diagnosis: _____ or Age at Onset: _____

(2) Most current Glycohemoglobin (HbA1C) test reading: _____ **Date:** _____ **Recent range:** _____
It is very important to have these numbers for any useful preunderwriting premium estimate. If the proposed insured is unaware of recent values for this test, please have her/him obtain these values from their health care provider. A typical value lies between 6 and 12, often expressed with a decimal, such as 7.3. Slightly higher or lower values are possible.

(3) How often does the proposed insured visit their physician for a diabetic checkup?

❒ Monthly ❒ Every 3 Months ❒ Every 6 Months ❒ Once a Year ❒ Less than Yearly

Date of most recent physician visit: _____ Date of next physician visit: _____

(4) The proposed insured controls his/her diabetes by:

❒ Diet Only ❒ Weight loss/control ❒ Regular exercise (indicate type and frequency): _____

❒ Oral Medication: _____ (medication, dosage, frequency) ❒ Insulin: _____ (units per day)

(5) Does the proposed insured take any other medication(s)? If yes, please list:

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(6) Recent readings:

Current Height: _____ Weight: _____ Weight one year ago: _____ Reason for change: _____

Blood sugar reading: _____ Fructosamine level: _____ Microalbumin Level: _____

Triglycerides: _____ Bad cholesterol (LDL): ___ Good cholesterol (HDL): _____ Blood Pressure: _____

(7) Has the proposed insured experienced any of the following? If yes, provide details below under question (8):

❒ Weight problems ❒ High blood pressure ❒ Chest Pain ❒ Insulin shock
❒ Coronary Artery Disease ❒ Abnormal ECG ❒ Elevated Lipids ❒ Diabetic coma
❒ Neuropathy ❒ Retinopathy ❒ Kidney Disease ❒ Alcohol/drug abuse
❒ Protein in the Urine ❒ Albuminuria ❒ Glycosuria ❒ Other

(8) Please provide any additional details regarding the proposed insured's medical condition:

_____

_____

_____