

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: _____

(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):*

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Weight problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Insulin shock |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Abnormal ECG | <input type="checkbox"/> Elevated Lipids | <input type="checkbox"/> Diabetic coma |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alcohol/drug abuse |
| <input type="checkbox"/> Protein in the Urine | <input type="checkbox"/> Albuminuria | <input type="checkbox"/> Glycosuria | <input type="checkbox"/> Other |

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