

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):**

<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:**

