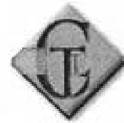


# DIABETES QUESTIONNAIRE

Proposed Insured's Name: DOB: Sex: ☐ M ☐ F

Tobacco Use: ☐ Yes ☐ No Amount: Height: Ft. In. Weight:

Broker's Name: Face Amount:

BGA: Phone: Fax:

Proposed Insured please answer the following:

1. Date you were diagnosed: Age at diagnosis:
2. Classification: ☐ Insulin ☐ Non-Insulin ☐ Diet ☐ Gestational
3. Do you test your own blood sugar and urine ☐ No ☐ Yes, How often?
4. Do you follow a diabetic diet or exercise? ☐ Yes ☐ No
5. Have you been diagnosed with or treated for any of the followin

   ☐ Retinopathy (Diabetes related eye problems) ☐ Kidney disease

   ☐ Neuropathy * ☐ Laser surgery

   ☐ Hypertension ☐ Protein in urine ☐ Heart conditions

   Details:

***If Neuropathy is present, please complete the Peripheral Vascular Questionnaire***

6. When was your last glycohemoglobin (A1C) test done?

   Who performed the test, and results:

7. Do you have any other major health problems? ☐ No ☐ Yes, Details:
8. Are you on any medication(s)? ☐ No ☐ Yes, Name(s) and dosage(s):
9. Have you had any reactions? ☐ No ☐ Yes, Type and frequency:
10. How often do you visit your physician?

    Date of last visit:

11. Name and address of your physician(s):

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Underwriter's Notes:

Date: __________ Proposed Insured's Signature: ____________________