Diabetic Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured first diagnosed with diabetes? _____

2. What was the diagnosis? ___ Type I ___ Type II

3. Does the proposed insured receive any of the following treatments? (Check all that apply.)

   ___ Diet control
   ___ Oral medication Name, dosage & frequency: _____
   ___ Insulin How many units per day? _____

4. How often does the proposed insured check their blood sugar? _____
   What was the most recent blood sugar reading? _____
   What was the most recent A1C reading? _____

5. How often does the proposed insured see their doctor for diabetes follow-up? _____

6. Has the proposed insured ever been in a diabetic coma? ___ Yes ___ No
   If yes, provide date and circumstances: _____
   _____

7. Is there any history of diabetes or heart disease in the proposed insured's family? ___ Yes ___ No
   If yes, provide relationship to proposed insured and age of onset: _____
   _____

8. Has the proposed insured experienced any of the following? (Check all that apply.)

   ___ Eye trouble Details: _____
   ___ Heart Disease or Chest Pain Details: _____
   ___ Poor circulation or leg cramps Details: _____
   ___ Kidney disease Details: _____
   ___ Neuropathy Details: _____

9. Is the proposed insured current taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) _____
   _____
   _____

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