



Diabetes Mellitus Questionnaire

Agent Name: _____ **Phone:** _____
Proposed Insured Name: _____ **Sex:** Male Female **DOB:** _____
Face Amount Requested: \$ _____ **Maximum Annual Premium:** \$ _____
Plan Type: UL WL Term Survivorship

Tobacco Use

Do you currently smoke cigarettes? Yes No
 If No, did you ever smoke? Never Quit (Date): _____
Do you currently use any other tobacco or nicotine products? (e.g., nicotine patch, cigars, pipe, snuff, gum) Yes No If Yes, provide details: _____
When did you last use any form of tobacco? MM/YY: _____ Type used last: _____

Diabetes History

Date of Diagnosis: _____ Age at Onset: _____
 Most Current Glycohemoglobin (HbA1C): _____ Recent Range: _____ Date: _____
**These numbers are necessary to provide an accurate pre-underwriting premium estimate. If the proposed insured does not know their most recent results, please ask them to obtain the values from their healthcare provider. Typical readings range from 6 to 12 and are often expressed with a decimal (e.g., 7.3), though slight variations above or below this range are common.*

How often does the proposed insured visit their physician for a diabetic checkup?
 Monthly Quarterly Every 6 Months Annually Less than Annually
 Date of most recent physician visit: _____ Date of next physician visit: _____

Blood Pressure ___/___ Height: _____ Current Weight: _____ Weight One Year Ago: _____
 Reason for Change: _____ Blood Sugar Reading: _____ Fructosamine Level: _____
 Microalbumin Level: _____ Triglycerides: _____ Bad LDL: _____ Good LDL: _____

Has the proposed insured experienced any of the following.? If yes, provide details.
 High Blood Pressure Weight Issues Chest Pain Insulin Shock
 Coronary Artery Disease Abnormal EKG Elevated Lipids Diabetic Coma
 Alcohol/Drug Abuse Retinopathy Kidney Disease Neuropathy
 Protein in Urine Albuminuria Glycosuria Other
 If yes, provide details: _____

The proposed insured controls their diabetes by?
 Diet Only Weight Loss/Control Insulin _____ (units per day)
 Regular Exercise (indicate type and frequency): _____
 Oral Medication (Please list in chart below.)

Medication List (Prescription and Over-the-Counter)

Medication Name	Dates Used	Quantity Taken	Frequency