

DIABETES

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____

Type of Coverage: Term UL Survivor **Type of Coverage:** Term UL Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date first diagnosed: _____

2. How often does your client visit his/her physician?: _____
 When was the last visit? _____

3. The client's diabetes is controlled by:

- Diet alone
 Oral medication (medication and doses) _____
 Insulin (amount and units/day) _____

4. Please give the most recent blood sugar reading: _____

5. Does client monitor his/her own blood sugar? _____

6. If available, please give the most recent glycohemoglobin (BhA1C) or fructosamine level: _____

7. Please check if your client has (had) any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain or coronary artery disease | <input type="checkbox"/> Protein in the urine | <input type="checkbox"/> Elevated lipids |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Abnormal ECG | <input type="checkbox"/> Hypertension |

8. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

9. Does client have any other health issues? (additional questionnaires may be required) No Yes; please give details

FAMILY HISTORY (ADDENDUM)

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

1. Has the proposed insured had relative(s) with any of the following:

Parent
 Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)
 Age of onset: _____ Date of death: _____

Brother
 Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)
 Age of onset: _____ Date of death: _____

Sister
 Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)
 Age of onset: _____ Date of death: _____

2. If yes to any of the above, please provide details/information
