

Diabetic Questionnaire

Agent Name: _____ Phone #: _____ E-mail: _____
Client Name: _____ Date of Birth: _____ Sex: Male / Female
Height: _____ Weight: _____ State: _____ Smoker: Y / N Face Amount: _____
Type of Insurance: Universal Life Whole Life Survivorship Term (# of years)

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

2. 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? _____

3. 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? _____

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

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

6. 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: _____

7. 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: _____

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

FAX TO 603-778-7918 or E-MAIL TO sdonovan@uinc.com.