QUESTIONNAIRE:
Diabetes Prequalification

Please complete the following questions with as many details as possible.
In this supplement, "you" and "your" mean the Proposed Insured.

Name of Proposed Insured: _____ DOB _____

Gender: ☐ M ☐ F Do you use Tobacco? ☐ Yes ☐ No

1. When were you first diagnosed with diabetes? Month: _____ Year: _____

2. Name and address of the medical professional who diagnosed you: _____

_____

3. Name and address of the medical professional currently treating you: _____

_____

4. How frequently do you visit your medical professional? _____

Date of most recent visit: _____

5. What is your current treatment for diabetes? Check all that apply:

☐ Diet

☐ Oral medication: give name(s) and dosage

_____

_____

☐ Insulin: give name(s) and dosage

_____

_____

If insulin, do you use a pump? ☐ Yes ☐ No

6. When did you last test your glycated hemoglobin (HbA1c)? _____

What was the result of your last test for glycated hemoglobin (HbA1c)? _____

7. In the last 10 years, have you been diagnosed by a medical professional as having any of the following?

Diagnosis	Yes	No	If yes, date of diagnosis	If yes, provide details of treatment
Retinopathy (eye disorder)	☐	☐		
Neuropathy (nerve damage)	☐	☐		
Diabetic coma	☐	☐		
Other diabetic complication	☐	☐		

8. Remarks. (Use this space for any additional information or details regarding the above questions.