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**DIABETES QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | **Last Name:** |  | |
| **Date of Birth** (mm/dd/yyyy): | |  | **Policy/Application No.:** | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. When was your diabetes diagnosed? | | |  | | | | Type: | | | | |  | |
| 1. Were you prescribed any medication for this condition? | | | | | | Yes (Please provide details.)  No | | | | | | | |
| Name of Medication | Date Prescribed | | | Frequency and Dosage | | | | Date Medication Stopped | | | | | Reason |
|  |  | | |  | | | |  | | | | |  |
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| 1. Do you know your last HBA1c reading within the last six (6) months? | | | | | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | | | | | |
| HBA1c Reading | | | | | | | | | | | Date | | |
|  | | | | | | | | | | |  | | |
|  | | | | | | | | | | |  | | |
| 1. Were there tests done in relation to Diabetes? | | | | | If **YES**, please provide details below.  No | | | | | | | | |
| Date | | Type of Test | | | | | | | Results | | | | |
|  | | HBA1c | | | | | | |  | | | | |
|  | | FBS | | | | | | |  | | | | |
|  | | OGTT | | | | | | |  | | | | |
|  | | Home Glucose Test | | | | | | |  | | | | |
|  | | Others: | | | | | | |  | | | | |
| 1. Have you ever had the following conditions? | | | | | Yes (Please provide details.)  No | | | | | | | | |
| Medical Condition | | | | | | | | | | Details | | | |
| Diabetic Coma | | | | | | | | | |  | | | |
| Eye Problems | | | | | | | | | |  | | | |
| High Blood Pressure | | | | | | | | | |  | | | |
| Amputation of upper or lower extremities or any part thereof | | | | | | | | | |  | | | |
| Kidney problems | | | | | | | | | |  | | | |
| Discoloration of Extremities | | | | | | | | | |  | | | |
| Pain/burning sensation or numbness on legs/feet | | | | | | | | | |  | | | |
| Elevated cholesterol level | | | | | | | | | |  | | | |
| Others: | | | | | | | | | |  | | | |
| 1. When was your latest doctor consultation regarding diabetes or diabetes related complication? | | | | | | | | | | | | | |
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| 1. Have you been admitted to a hospital/facility due to this condition? | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | |
| Date Admitted | Date Discharged | | | Name of Hospital/Facility | | | | | Reason for Confinement |
|  |  | | |  | | | | |  |
|  |  | | |  | | | | |  |
| 1. Do you smoke? | | | Yes (Please provide details.)  No | | | | | | |
| Type | | | Details (Number of sticks/packs/ml per day) | | | | | | |
| Cigarettes | | |  | | | | | | |
| E-cigarettes | | |  | | | | | | |
| Vape | | |  | | | | | | |
| Smokeless Tobacco | | |  | | | | | | |
| 1. Do you consume alcohol? | | | Yes (Please provide details.)  No | | | | | | |
| Type | | | | | | Frequency | Quantity (bottle/shot/can/glass) | | |
| Beer | | | | | |  |  | | |
| Wine | | | | | |  |  | | |
| Spirits (e.g., Brandy, Gin, Whisky, Rhum, Vodka, etc.) | | | | | |  |  | | |
| Ready to drink mixers (RTD’s) | | | | | |  |  | | |
| 1. Please provide additional information that you feel is important. | | | | | | | | | |
|  | | | | | | | | | |
| 1. Are you currently under medical supervision? | | | | | Yes (Please provide details.)  No | | | | |
| Name of Doctor, Hospital or Clinic | | Address | | | | | | Date of Last Consultation (Month/Year) | |
|  | |  | | | | | |  | |
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| **DECLARATION** |
|  |
| **I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.**  **I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.** |

|  |  |
| --- | --- |
| **Name:** |  |

|  |  |
| --- | --- |
| **Signature:** |  |

|  |  |
| --- | --- |
| **Date of Signing:** |  |

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