

**DIABETES QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

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

