



# EMG

## Insurance Brokerage **DIABETES MELLITUS QUESTIONNAIRE**

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of birth: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_ / year  UL  WL  Term  Survivorship

Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):  Y  N

If Yes, please provide details: \_\_\_\_\_

When did you last use any form of tobacco: \_\_\_\_ (Month) \_\_\_\_ (Year) Type used last: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

**(1) Date of diagnosis:** \_\_\_\_\_ **or Age at Onset:** \_\_\_\_\_

**(2) Most current Glycohemoglobin (HbA1C) test reading:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Recent range:** \_\_\_\_\_  
*It is very important to have these numbers for any useful preunderwriting premium estimate. If the proposed insured is unaware of recent values for this test, please have her/him obtain these values from their health care provider. A typical value lies between 6 and 12, often expressed with a decimal, such as 7.3. Slightly higher or lower values are possible.*

**(3) How often does the proposed insured visit their physician for a diabetic checkup?**  
 Monthly  Every  Months  Every 6 Months  Once a Year  Less than Yearly  
 Date of most recent physician visit: \_\_\_\_\_ Date of next physician visit: \_\_\_\_\_

**(4) The proposed insured controls his/her diabetes by:**  
 Diet Only  Weight loss/control  Regular exercise (indicate type and frequency): \_\_\_\_\_  
 Oral Medication: \_\_\_\_\_ (medication, dosage, frequency) Insulin: \_\_\_\_\_ (units per day)

**(5) Does the proposed insured take any other medication(s)?** If yes, please list:

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

**(6) Recent readings:**  
 Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Reason for change: \_\_\_\_\_  
 Blood sugar reading: \_\_\_\_\_ Fructosamine level: \_\_\_\_\_ Microalbumin Level: \_\_\_\_\_  
 Triglycerides: \_\_\_\_\_ Bad cholesterol (LDL): \_\_\_\_\_ Good cholesterol (HDL): \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

**(7) Has the proposed insured experienced any of the following? If yes, provide details below under question (8):**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Weight problems         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Insulin shock      |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Abnormal ECG        | <input type="checkbox"/> Elevated Lipids | <input type="checkbox"/> Diabetic coma      |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Retinopathy         | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Alcohol/drug abuse |
| <input type="checkbox"/> Protein in the Urine    | <input type="checkbox"/> Albuminuria         | <input type="checkbox"/> Glycosuria      | <input type="checkbox"/> Other              |

**(8) Does the proposed insured have any other medical conditions? If yes, please describe:**

\_\_\_\_\_

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\_\_\_\_\_