

TIC Financial Services
DIABETES QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
Address: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

1. Date you were diagnosed: _____ Age at diagnosis: _____
2. Classification: Insulin Non-Insulin Diet Gestational
3. Do you test your own blood sugar and urine? No Yes, How often?
4. Do you follow a diabetic diet or exercise? Yes No
5. Have you been diagnosed with or treated for any of the following?
 Retinopathy (Diabetes related eye problems) Kidney disease
 Neuropathy * Laser surgery
 Hypertension Protein in urine Heart conditions

Details:

*** If Neuropathy is present, please complete the Peripheral Vascular Questionnaire**

6. When was your last glycohemoglobin (A1C) test done?

Who performed the test, and results:

7. Do you have any other major health problems? No Yes, Details:

8. Are you on any medication(s)? No Yes, Name(s) and dosage(s):

9. Have you had any reactions? No Yes, Type and frequency:

10. How often do you visit your physician?

Date of last visit:

11. Name and address of your physician(s):

Date: _____ Proposed Insured's Signature: _____