Assumption Life

# Diabetes Questionnaire

First Name : ______________________________ Last Name : ______________________________
Policy Number : ______________________________ Date of Birth : ______________________________

1. Name and address of your attending physician: ______________________________

2. At what age were you diagnosed with diabetes? ______________________________

3. Treatment: ☐ Diet ☐ Oral medication ☐ Insulin
   If taking oral medication or insulin, please indicate the name, dosage and frequency of treatment.

| **Medication/Insulin** | **Dosage** | **Frequency** |
|---|---|---|
| | | |
| | | |
| | | |

4. Do you regularly check your blood glucose (blood sugar level)? ☐ Yes ☐ No
   Please indicate the date, time and result of your last 3 readings

| **Date** | **Time** | **Result** |
|---|---|---|
| | | |
| | | |
| | | |

5. Has your blood pressure been checked in the last 6 months? ☐ Yes ☐ No
   If yes, please indicate the date and result of your last blood pressure readings.

| **Date** | **Result** |
|---|---|
| | |
| | |
| | |

6. Have you ever had any of the following conditions? ☐ Yes ☐ No

- ☐ Heart or circulatory disorder
- ☐ Elevated cholesterol
- ☐ Protein in the urine or other kidney disorder
- ☐ Neurological problem or numbness or a tingling sensation in the limbs
- ☐ Diabetic coma or an insulin reaction
- ☐ High blood pressure
- ☐ Vision impairment

Please give full details (date, diagnosis, treatment, result of any tests and name of physician consulted): ______________________________

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

______________________________ ______________________________
Signature of the person to be insured (parent or legal guardian if a minor) Date



**Assumption Mutual Life Insurance Company**, doing business under the name Assumption Life,
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