NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

DIABETES QUESTIONNAIRE

1. **Date Diabetes Diagnosed:** _____/_____/_____ (D / M / Y)

2. **Are you currently under medical treatment?** Yes ☐ No ☐

3. **Name and address of the doctor now treating you and for how many years?** _____

   _____

4. **Date of last visit:** _____

5. **Provide the type of treatment and dosage of**

   ☐ Insulin Dosage: _____

   ☐ Oral Medication Dosage: _____

6. **Do you follow a diabetic diet?** Yes ☐ No ☐

   Exercise program? Yes ☐ No ☐

7. **Do you test yourself your sugar levels with a glucometer?** Yes ☐ No ☐

   If yes, frequency and results of the last 3 readings: _____

8. **How many times per year do you have your blood glucose levels measured by your doctor?** _____

   Date and result of the last blood glucose level measured by your doctor: _____

9. **Have you ever had any diabetic comas or insulin reactions?** Yes ☐ No ☐

   If yes, provide date(s): _____

10. **Have you ever had any:**

☐ Cardiac and Vascular Disorders	☐ Retinopathy and/or Cataracts
☐ Pulmonary Disorders	☐ Albumin in urine
☐ Kidney Disorders	☐ Neuritis and Rheumatism
☐ High Blood Pressure	☐ Neuropathy
☐ Skin Disorders	☐ Comas

11. **Please provide any additional information:** _____

    _____

    _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ X_____

SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X_____ _____

WITNESS **DATE**