Policy Number/s

DIABETES MELLITUS QUESTIONNAIRE - Applicant
(To form part of the policy contract)

Name of Applicant: _____

1. When was diabetes diagnosed? _____ Type: _____

2. Where you prescribed any medication for this condition? ◯ YES, *please provide details* ◯ NO

Date Prescribed	Name of Medication	Dosage	Date medication stopped & reason/s	
/ /	**Oral Medications:**		/ /	
/ /			/ /	
/ /			/ /	
/ /	**Insulin:**		/ /	
/ /			/ /	
/ /			/ /	

3. Do you know your last HBA1C reading within the last 6 months? ◯ YES ◯ NO

If yes, what was your last HBA1C reading? _____ Date: _____

4. What other tests were done in relation to diabetes?

Date	Type of test	Result
/ /	◯ HBA1C	
/ /	◯ FBS	
/ /	◯ OGTT	
/ /	◯ Home Glucose Test	
/ /	◯ Others:	

5. Have you ever had the following conditions? *(Please provide details e.g. date of admission, etc.)*

✓ MEDICAL CONDITIONS	DETAILS
◯ Diabetic Coma	
◯ Eye Porblems	
◯ Heart Problems	
◯ High Blood Pressure	
◯ Amputation of upper or lower extremities or any part thereof	
◯ Kidney problems: *e.g. elevated creatinine, low e-GFR, protein in urine, etc.*	
◯ Discoloration of Extremities	
◯ Pain/burning sensation or numbness on legs/feet	
◯ Others:	

6. 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
/ /	/ /		
/ /	/ /		

7. Do you smoke? ◯ YES, *please provide details below* ◯ NO

Cigarettes	◯ YES	◯ NO	Number of	Sticks/day	
E-cigarettes	◯ YES	◯ NO		Packets/day	
Vape	◯ YES	◯ NO		Months/years	
Smokeless tobacco	◯ YES	◯ NO	mL per day (for vaping)		

8. Are you currently under medical supervision? ◯ YES, *please provide details* ◯ NO

Name of Attending Physician:
Specialization:
Contact Number:
Clinic Address:
Email Address:

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 understand that the personal information collected or held by AXA Philippines may be used, stored, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including any of its affiliates or related companies, or any individuals/organizations/corporations/entities associated with AXA Philippines to process and deal with my application/policy to which this is appended to.

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 and Signature Date of Signing

AXA PHILIPPINES

34F GT TOWER INTERNATIONAL

6813 Ayala Avenue corner H.V. Dela Costa St. | Makati City 1226, Philippines