Policy Number

PRE-DIABETES/DIABETES MELLITUS QUESTIONNAIRE - APPLICANT
(To form part of the policy contract)

Name of Applicant: _____

1. Have you been diagnosed with the following conditions?

Please check	Type of Diabetes	Date of Diagnosis
◯	Diabetes Mellitus Type 1 or Insulin Dependent Diabetes Mellitus	/ /
◯	Diabetes Mellitus Type 2 or Non-Insulin Dependent Diabetes Mellitus	/ /
◯	Impaired Glucose Tolerance or Impaired Fasting Glucose (Pre-diabetes)	/ /
◯	Gestational Diabetes	/ /

2. Were you prescribed medication/s for this condition? ◯ YES, *please provide details* ◯ NO

Date Prescribed (mm/dd/year)	Name of Medication	Dosage	Date Medication Stopped (mm/dd/year) and 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. Have other tests been done in relation to your condition (diabetes, pre-diabetes, or gestational diabetes)?

Date (mm/dd/year)	Type of Test	Result
/ /	◯ FBS ◯ OGTT	
/ /	◯ Urinalysis	
/ /	◯ Home Glucose Test	
/ /	◯ Others:	

5. Have you ever had, or do you currently suffer from any of the following? ◯ YES ◯ NO

Amputation of upper or lower extremities or any part thereof	◯ YES ◯ NO
COVID-19	◯ YES ◯ NO
Diabetic Coma	◯ YES ◯ NO
Eye Problems *e.g., Retinopathy*	◯ YES ◯ NO
Heart Problems *e.g., coronary artery disease*	◯ YES ◯ NO
Hepatitis B Virus (HBV)	◯ YES ◯ NO
High Blood Pressure or Hypertension	◯ YES ◯ NO
Hypercholesterolemia	◯ YES ◯ NO
Kidney problems: *e.g., Chronic Kidney Disease, Polycystic Kidney Disease, elevated creatinine, low e-GFR*	◯ YES ◯ NO
Neuropathy or Pain/burning sensation or numbness on legs/feet	◯ YES ◯ NO
Stroke/Transient Ischemic Attack (TIA)	◯ YES ◯ NO
Urine Abnormality *e.g., protein, blood in urine, and/ or ketones in urine*	◯ YES ◯ NO
Others:	◯ YES ◯ NO

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:	**Email Address:**
Clinic 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 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.

*Name and Signature	Date of Signing

**To be completed and signed by the Proposed Owner if application is for a Minor.*

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