



DIABETES QUESTIONNAIRE

TO BE FILLED BY THE APPLICANT

Name of the Life Insured

Application Number

PLEASE ANSWER EACH QUESTION AND PROVIDE PARTICULARS WHEREVER REQUIRED

- When was your diabetes or IFG or IGT or increased blood sugar first diagnosed? _____
- Please state the type of diabetes you are suffering from:
 - Type 1 (Insulin dependent)
 - Type 2 (Non-insulin dependent)
 - Gestational diabetes
- What is the nature of your treatment at present? Exercise and Diet Control Tablets Insulin
 If 'Yes' for insulin or tablets, mention the type: _____
 Dosage: _____
 What was the earlier treatment? _____
- Do you suffer from any complaint related to diabetes like increased thirst, increased hunger, frequent urination, unexplained weight loss, fatigue, dry mouth, etc.: _____
 Have you had problems with infections? Yes No
 Please mention what kind of infection (Like acne, burning on urination, frequent colds, itching in groin or feet, boils). _____
- Do you test blood sugar? How often: Monthly Randomly Half yearly Yearly
 Please mention your last two readings and dates: I.) _____ II.) _____
 How often do you get a urine test done to check for sugar? Monthly Half-yearly Annually Randomly Never
- Have you ever been told you have:
 - High blood pressure Yes No
 - Eye abnormality Yes No
 - Nerve problem Yes No
 - Kidney problem Yes No
 - Heart disease Yes No
- Do you have any history of uncontrolled blood sugar continuously for more than 15 days or diabetic Coma or insulin shock, hypoglycaemia or long non-healing wound? Yes No
 If 'Yes', please provide details: _____

- Have you ever undergone medicals like TMT, chest x-ray, ECG or any other test? Yes No
 If 'Yes', please mention the test results: _____

 Has there been a change in your treatment in the last 2 years? If 'Yes', please mention when and why. Please attach your prescriptions/consultation notes: _____
- Have you ever been hospitalised for complications of diabetes? If 'Yes', please share your discharge summary:

10. Do you consume alcohol, smoke or use tobacco in any form?

Yes No

If 'Yes':

a) How many cigarettes/bidis/cigars/pipes do you smoke per day? _____

b) How much alcohol do you consume per day? _____ ml/day

c) Your alcohol of choice: Wine / Beer / Whiskey / Gin / Rum / Vodka / Spirit

(Please tick (√) whichever is applicable)

11. Please provide the name and address of your physician along with the latest follow-up notes: _____

_____ Date of your last consultation: _____

12. Please provide any additional information that would help in processing your application: _____

**Please submit reports of any blood tests, urine test, lipid profile, ECG, or any other tests done in last one year.

I hereby declare, and agree that the above particulars and answers are complete and true; and this questionnaire will form a part of the contract of the desired insurance on my life.

Place: _____ Date: _____

Signature of the Life Insured

**Please tick (√) wherever applicable.

VERNACULAR DECLARATION

I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: _____

Address of the Declarant: _____

Signature of the Declarant

Place: _____ Date: _____

Signature of the Life Insured