Diabetes/Endocrine Disorders **Questionnaire**

(Insulin resistance / Type 1 diabetes / Type 2 diabetes)

Application reference number

The questionnaire must be completed by the Life Insured.

Important: No compensation is payable if a Medical Examiner compleres this questionnaire.

Particulars of Life Insured

First name(s)

Last name

Identity no./passport no. (compulsory)

Date of birth D D M M Y Y Y Y

Address

Postal code

General questions

State the nature of your condition:

Date of the diagnosis: D D M M Y Y Y Y

What sort of treatment do you currently receive?

Insulin ☐ Yes ☐ No

If 'yes', please state the name(s) of your insulin and dosage/number of units for each type:

Oral drugs ☐ Yes ☐ No

If 'yes', please provide details including dosage:

Any other medication? ☐ Yes ☐ No

If 'yes', please provide details including dosage:

Are you on a special/restricted diet? ☐ Yes ☐ No

If 'yes', please provide further details:

Do you attend a regular diabetic clinic? ☐ Yes ☐ No

If 'yes', please provide further details including the nature of check-ups and frequency of your attendance:

Do you monitor your:

Blood sugar levels ☐ Yes ☐ No

If 'yes', what are your average results?

State the typical range of your results:

Urine sugar levels ☐ Yes ☐ No

If 'yes', what are your average results?

Do you meassure your blood sugar levels at home with a monitor? ☐ Yes ☐ No

If 'yes', how often?

☐ Daily ☐ Weekly ☐ Monthly ☐ Other

Please specify other:

Please provide results of your three most recent tests:

Date and time D D M M Y Y Y Y

Results mmol/L

Date and time D D M M Y Y Y Y

Results mmol/L

Date and time D D M M Y Y Y Y

Results mmol/L

How often do you consult your doctor about your condition? ☐ Annually ☐ Six monthly

Other (please provide full details):

Please state whether you have experienced any of the following conditions. If so, please tick the condition and provide further details in the space below.

High blood pressure	☐	
Infections (eg boils)	☐	
Numbness, loss of feeling in feet/legs	☐	
Circulatory disorders (eg cold feet)	☐	
Kidney problems	☐	
Albumin or protein in urine	☐	
Eye problems	☐	
Heart problems	☐	
Diabetic coma	☐	
Stroke	☐	
Abnormal ECG	☐	

Please indicate the following, if applicable:

Last cholesterol level ☐

Last triglyceride level ☐

Chest x-ray result ☐ Normal ☐ Abnormal ☐ Unknown

Please provide full details:

Please provide any further relevant information. This should include the name/s and address/es of any doctors, specialists, opthalmologists (eye specialists and/or podiatrists to whom you have been referred:

Name of medical doctor

Nature of specialism/consultation

Postal address

Postal code

Name of medical doctor

Nature of specialism/consultation

Postal address

Postal code

Name of medical doctor

Nature of specialism/consultation

Postal address

Postal code

Declaration by Life Insured

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Date

D	D	M	M	Y	Y	Y	Y

Signature

If you require any further details, please ask your financial adviser.

Alternatively you can contact your nearest Unisure office, details of which are available on our website, or get in touch using our email address: admin.life@unisuregroup.com

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