M. WILLIAMSON INSURANCE SERVICES
LIFE INSURANCE | DISABILITY INSURANCE | LONG-TERM CARE INSURANCE

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Diabetes

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date first diagnosed: _____

2. How often does your client visit his/her physician?: _____

   When was the last visit? _____

3. The client's diabetes is controlled by:

☐ Diet alone
☐ Oral medication (medication and doses) _____
☐ Insulin (amount and units/day) _____

4. Please give the most recent blood sugar reading: _____

5. Does client monitor his/her own blood sugar? _____

6. If available, please give the most recent glycohemoglobin (BhA1C) or fructosamine level: _____

7. Please check if your client has (had) any of the following:

☐ Chest pain or coronary artery disease ☐ Protein in the urine ☐ Elevated lipids
☐ Overweight ☐ Neuropathy ☐ Kidney disease
☐ Retinopathy ☐ Abnormal ECG ☐ Hypertension

8. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

9. Does client have any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____