

Life Scan Questionnaire for **DIABETES**

LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For _____ [] Male [] Female
Date of Birth _____ Age _____ State _____
Height _____ Weight _____ [] Non Smoker [] Smoker
Have you ever used tobacco? [] Yes [] No If Yes, state month
and year of last use of any tobacco product: _____
Type of tobacco used [] Cigarettes [] Cigars [] Chews [] Pipe
Amt \$ _____ Type [] Whole Life, Variable or Universal [] Term
Last application for life insurance: Year _____ Company _____
Result : [] Preferred [] Standard [] Rated Rating _____ [] Declined
[] Life Insurance Risk Evaluation and Market Search for Best Offer
[] Risk Evaluation Only

Age at onset of diabetes? _____ [] Type I [] Type II

What is the method of control?

- [] Diet only?
 - [] Diet and oral medication?
 - [] Diet and insulin?
- List medications _____

How many times per day do you administer your insulin?

- [] I am on an insulin pump
- [] One or two times per day
- [] Three or more per day

How often do you monitor blood sugar levels?

- [] One or two times per day ?
- [] Three or more times per day?

Please mark below, If you have had any of the following:

- [] EKG abnormalities?
- [] Insulin reaction?
- [] Diabetic coma?
- [] Any eye trouble ?
- [] Heart Trouble?
- [] Protein in the urine?
- [] Skin Ulceration?
- [] Amputation?
- [] Numbness or loss of sensation?

Other _____

Please explain any questions marked above:

Have you in the past 6 months had a Glyco-hemoglobin A1C test?

- [] Yes [] No If yes above, what was the level?
- [] Below 6.5 [] 6.6 to 7.5 [] 7.6 to 8.5 [] 8.6 to 9.5 [] 9.6 to 10.9 [] 11 to 12.9 [] 13 or more

Date last seen by a physician or medical practitioner?

Month _____ Year _____ Reason _____

Life Factors

Date of last stress EKG /
Month ____ Year ____ [] Never

Family History, has either
parent or any sibling died
before age 65?

[] Yes [] No If yes, please
list cause and age.

Blood Pressure, with or without
medication ____ / ____
List medication, if any

Result of last **Cholesterol** test,
if known _____

List all **other illnesses** not
listed on this page.

List all medications currently
being used except those
previously listed.
(name, dosage and times per day)

Agent Information

Name _____

Address _____ Suite _____

City _____

ST ____ Zip ____ email _____



United Producers Insurance Services
PO Box 71339, Salt Lake City UT 84171
801-713-0800 Fax 801-713-0805
Toll Free 888-888-7441 Fax 888-888-7449

This is not an application for life insurance. The information contained herein will be used solely for the purpose of assessing which insurance carriers are likely to respond most favorably to the risk situation as stated above. The questions and answers listed will be used in the evaluation of the person listed above. All quotes are tentative, and are subject to the submitted medical evidence and other criteria used in the underwriting of life insurance. Copyright 1997 George Varanakis