

QUICK QUOTE FOR DIABETES

CLIENT: NAME _____ / M F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. UL TERM YRS. LVL _____

TOBACCO USE NO YES, TYPE _____ / REPLACEMENT YES NO / CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

FAMILY HISTORY –
AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH _____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET _____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? NO YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ RESULTS _____

DATE OF LAST RESTING EKG _____ RESULTS _____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____ / ARE YOU TREATED FOR BLOOD PRESSURE? NO YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____ / ARE YOU TREATED FOR CHOLESTEROL? NO YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. DATE DIAGNOSED WITH DIABETES: _____

2. SPECIFY TYPE OF DIABETES:

- TYPE 1
 TYPE 2

3. HOW IS YOUR DIABETES TREATED?:

- DIET ONLY ORAL MEDICATION(S)*
 INSULIN INJECTION * INSULIN PUMP*

*LIST UNITS OF INSULIN OR MEDICATION(S) AND DOSAGE:

4. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?
CHECK ALL THAT APPLY AND INCLUDE DATES:

- EKG ABNORMALITIES _____
 INSULIN REACTIONS _____
 DIABETIC COMA _____
 EYE TROUBLE (RETINOPATHY) _____
 HEART TROUBLE _____
 PROTEIN/MICROALBUMIN IN URINE (NEPHROPATHY) _____
 SKIN ULCERATION _____
 AMPUTATIONS _____
 LOSS OF FEELING (NEUROPATHY) _____
 OTHER _____

5. PROVIDE MOST RECENT HEMOGLOBIN A1c LEVELS:

DATE AND RESULT _____
DATE AND RESULT _____
DATE AND RESULT _____

6. PROVIDE MOST RECENT MICROALBUMIN RESULT, IF AVAILABLE (THIS IS A URINE TEST FOR PROTEIN):

7. DATE OF YOUR LAST VISIT TO A PHYSICIAN AND RESULTS:

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS:
