

# QUICK QUOTE Diabetes



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Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance. © COPYRIGHT LifeBrokers.

**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 GIVE RELATION, AGE AND CAUSE, OF EACH \_\_\_\_\_  
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 \_\_\_\_\_ / DATE OF LAST EKG \_\_\_\_\_ AND RESULTS \_\_\_\_\_  
LAST BLOOD PRESSURE READING (RESULTS) \_\_\_\_\_ / \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE  NO  YES  
LAST CHOLESTEROL READING, HDL READING (RESULTS) \_\_\_\_\_, \_\_\_\_\_ TREATED FOR CHOLESTEROL  NO  YES  
**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

1. CLIENT'S AGE AT ONSET OF DIABETES \_\_\_\_\_
2. WHAT IS THE METHOD OF CONTROL?  
 DIET ONLY  
 DIET AND ORAL MEDICATION(S)\*  
 DIET AND INSULIN INJECTION  
\*LIST MEDICATIONS \_\_\_\_\_
3. HAS CLIENT ALWAYS BEEN ON INSULIN?  
 YES  NO, IF NOT, LENGTH OF TIME ON INSULIN \_\_\_\_\_
4. HOW MANY TIMES PER DAY IS INSULIN ADMINISTERED?  
 ONE OR TWO TIMES PER DAY  
 THREE OR MORE TIMES PER DAY  
 INSULIN PUMP
5. HOW OFTEN ARE BLOOD SUGAR LEVELS MONITORED?  
 ONE OR TWO TIMES PER DAY  
 THREE OR MORE TIMES PER DAY
6. PLEASE NOTE ANY/ALL OF THE FOLLOWING EXPERIENCED:  
 EKG ABNORMALITIES  
 INSULIN REACTIONS  
 DIABETIC COMA  
 EYE TROUBLE  
 HEART TROUBLE  
 PROTEIN IN URINE  
 SKIN ULCERATION  
 AMPUTATIONS  
 NEUROPATHY OR LOSS OF FEELING  
 OTHER \_\_\_\_\_

7. PLEASE DETAIL ANY INDICATIONS FROM QUESTION #6, SUCH AS: TYPE OF, DATE OF, FREQUENCY OF OCCURRENCE:  
\_\_\_\_\_  
\_\_\_\_\_

8. HAS CLIENT HAD A GLYCOHEMOGLOBIN (A1C) TEST DURING THE PAST SIX MONTHS?

NO  YES, PLEASE DETAIL LEVEL: \_\_\_\_\_ ENTER VALUE OF 0.0 – 15.0 (NORMAL RANGE OF LESS THAN 6.5 = EXCELLENT CONTROL; VALUES GREATER THAN 10.0 = POOR CONTROL)

9. HOW LONG HAS GLYCOHEMOGLOBIN LEVEL REMAINED CONSTANT?

0 TO 6 MONTHS  
 6 TO 12 MONTHS  
 OVER A YEAR

10. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

0 TO 6 MONTHS  
 6 TO 12 MONTHS  
 OVER A YEAR

11. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):  
\_\_\_\_\_