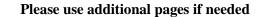
Diabetic Questionnaire - Tentative offers obtained are not binding and could be subject to change - Final offers are subject to formal application and review of all required age/face requirements, paramedical requirements and review of complete medical records. Agent/Advisor Name: Proposed Insured: Date Of Birth: Gender: Male □ or □ Female Build: Height_____ Weight____ Any Weight Loss In Last Year? If so how much _____ Product Desired: Term □ Guarantee UL□ Index UL□ Whole Life□Survivorship Life □ Face Amount Desired: Option 1 \$_____ Option 2 \$_____ Option 3\$_____ Maximum Premium Tolerance Per Year: Has Client Ever Used Any Form Of Nicotine? No \square Yes \square Type: □ Cigarettes □ Cigars □ Pipe □ Chew □ Patch □ Nicorette Gum □ E-Cigarette □ Vape Frequency: _____ Date Last Used___ Current Alcohol Use: Type______ Number of Drinks: _____ Per ____ Day ____ Week Date Last Used: _____ 1) What was your date of diagnosis? _____ What was your age at onset? ____ 2) What type of diabetes do you have? \Box Type 1 Diabetes \Box Type 2 Diabetes \Box Gestational Diabetes (pregnancy) 3) Provide your two most recent HbA1c readings and dates of those results: 4) Provide your most recent blood glucose and urine glucose tests results and date of those results: 5) What is your average fasting blood sugar? _____ 6) How often to you visit your physician for a diabetic checkup? □Monthly □Every 3 months □Every 6 months \square Once per year \square Less than yearly 7) How do you control your blood sugar? □Diet/exercise □ Insulin □Oral medication □Insulin pump Please provide medication name(s), dosage(s), insulin list units and frequency 8) Has your treatment varied in the last 12 months? \square Yes \square No If yes; provide details 9) Do you currently have or have had in past any of the following? \square Coronary artery disease \square Stroke □ Amputation □ Black out spells □ Neuropathy □ Retinopathy □ Kidney Disease □ Elevated lipids □ Protein in your urine Diabetic Coma High or Low blood sugar levels requiring emergency treatment Circulation Problems If yes; to any of the above please provide details 10) Have you ever been admitted to the hospital to control your diabetes? ☐Yes ☐No If yes; provide complete details 11) Is there family history of heart disease or cancer? \Box Yes \Box No If yes; provide details including relationship to yourself, age of onset, type and current age or date of death 12) Do you exercise three or more times per week on a regular basis? \square Yes \square No If yes; provide details 13) Have you made any lifestyle changes to improve your overall health? \square Yes \square No If yes; provide details 14) Are you being treated for any other medical conditions? \square Yes \square No If yes; provide details



15) Please list all other current medications, dosages and what condition the medication is treating



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