Underwriting Specialists, Inc.
PO Box 409, Ft. Washington, PA 19034-0409

DIABETES QUESTIONNAIRE

Attached to and made part of my inquiry for insurance.

Name_____

1. Height:_____ Weight:_____ Unchanged since:_____ Weight two years ago:_____
2. Date Diabetes diagnosed:_____
3. Name and address of doctor making the diagnosis:_____

   _____
4. Are you receiving treatment or under medical supervision now?_____

   _____
5. Give name and address of doctor treating you:_____

   _____
6. Medications and amount: (Please list medication, amount and how taken)

   a) Insulin:_____

   b) Oral medication:_____

   c) Other medications:_____
7. Do you ever stop the insulin or go off your diet?_____
8. Does urine show sugar? Occasionally:_____ Frequently:_____ Never:_____

   How often is sugar tested?_____
9. Home blood glucose monitoring: How often?_____ Results range:_____
10. Have you ever had the following? Specify "Yes" or "No"

    Eye trouble:_____ Numbness/tingling of the extremities:_____ Carbuncle:_____

    Ulcers of the legs (painless or painful?):_____ Boils:_____ Urinary Infections:_____

    Rectal abscess:_____ Genital infections:_____ Gum & tooth infections:_____
11. Have you ever had chest pains or been under suspicion or treatment for possible heart trouble?_____

    _____

12. Have you had pains in your feet or legs on walking?_____ While going to sleep:_____

13. Has an electrocardiogram been taken?_____ Date:_____

By whom:_____

14. Has an x-ray of the chest been taken?_____ Date:_____

By whom:_____

15. When did you last lose time from work?_____

Reason:_____

16. When were you last in a hospital?_____

Reason:_____

I represent that all my answers and statements are complete and true and correctly recorded before being signed below.

Signed at_____ this _____ day of _____, year _____

_____ _____

Witness Proposed Insured