

Endocrine disorders questionnaire

(Insulin resistance / Type 2 diabetes/ Type 1 diabetes)
(by insured life)

Policy number
Member number*
Group number* (*Fill in for FundsAtWork)

1: Details of insured life

Name of insured life
Permanent identity/passport number Permanent identity number Yes ☐ No ☐
Date of birth Telephone
Financial adviser's name Financial adviser code
Broker house code Telephone

2: General questions

1. What was the diagnosis?
2. Provide the date of the diagnosis.
3. What treatment do you receive?
 - 3.1 Insulin? Yes ☐ No ☐
If "yes", state the number of units per day:
 - 3.2 Oral medication? Yes ☐ No ☐
If "yes", state the number of units per day:
 - 3.3 Any other medication? Yes ☐ No ☐
If "yes", provide full details:
 - 3.4 Was your medication changed in the last 12 months? Yes ☐ No ☐
If "yes", provide full details:
 - 3.5 Are you on a diet? Yes ☐ No ☐
 - 3.6 Do you exercise? Yes ☐ No ☐
If "yes", how often One or two times a week ☐ More than two times a week ☐
What types of exercise do you do? Walking ☐ Running ☐ Other ☐
If "other", provide full details:
 - 3.7 Are you a member at a diabetic clinic?? Yes ☐ No ☐
If "yes", what is the name of the clinic you visit?
4. Do you monitor your:
 - 4.1 Blood sugar levels? Yes ☐ No ☐
If "yes", what are your average results?
 - 4.2 Urine sugar levels? Yes ☐ No ☐
If "yes", what are your average results?
5. Do you measure your blood sugar levels at home with a monitor? Yes ☐ No ☐
If "yes", how often? Daily ☐ Weekly ☐ Monthly ☐

2: General questions (continued)

6. Provide results and dates of the last three tests:

Date

D	D	M	M	Y	Y	Y	Y
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Results

6 - 6.5	
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6.6 - 7.0	
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Other			
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Date

D	D	M	M	Y	Y	Y	Y
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Results

6 - 6.5	
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6.6 - 7.0	
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Other			
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Date

D	D	M	M	Y	Y	Y	Y
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Results

6 - 6.5	
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6.6 - 7.0	
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Other			
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7. How often do you consult your doctor about your condition?

Monthly

Every three months

Other

If "other", provide full details:

8. Have you ever or do you currently have:

High blood pressure

Yes

No

Infections, (e.g. boils, ulcers)

Yes

No

Numbness, tingling, loss of feeling in feet/legs

Yes

No

Circulatory disorders (e.g. cold feet)

Yes

No

Kidney problems

Yes

No

Albumin or protein in urine

Yes

No

Eye problems

Yes

No

Heart problems

Yes

No

Diabetic coma

Yes

No

Stroke

Yes

No

Abnormal ECG

Yes

No

If "yes", provide further detail regarding the complications indicated, if any:

9. Indicate the following, if applicable:

Last cholesterol level

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Last triglyceride level

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Chest x-ray result

Normal

Abnormal

Unknown

Provide full details:

10. Have you been hospitalised for diabetes in the last 12 months?

Yes

No

11. Provide any further relevant details, including the name/s and address/es of any medical doctors, including physician specialists, ophthalmologists (eye specialists) and/or podiatrists you were referred to:

Name of medical doctor

Postal address

Postal code

Name of medical doctor

Postal address

Postal code

Name of medical doctor

Postal address

Postal code

3: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

Signature of insured life

Date

D

D

M

M

Y

Y

Y

Y