

2: General questions (continued)

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

Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Results	<input type="text" value="6 - 6.5"/> <input type="text"/>	<input type="text" value="6.6 - 7.0"/> <input type="text"/>	Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Results	<input type="text" value="6 - 6.5"/> <input type="text"/>	<input type="text" value="6.6 - 7.0"/> <input type="text"/>	Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Results	<input type="text" value="6 - 6.5"/> <input type="text"/>	<input type="text" value="6.6 - 7.0"/> <input type="text"/>	Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

7. How often do you consult your doctor about your condition?

If "other", provide full details:

8. Have you ever or do you currently have:

High blood pressure	Yes	<input type="text"/>	No	<input type="text"/>
Infections, (e.g. boils, ulcers)	Yes	<input type="text"/>	No	<input type="text"/>
Numbness, tingling, loss of feeling in feet/legs	Yes	<input type="text"/>	No	<input type="text"/>
Circulatory disorders (e.g. cold feet)	Yes	<input type="text"/>	No	<input type="text"/>
Kidney problems	Yes	<input type="text"/>	No	<input type="text"/>
Albumin or protein in urine	Yes	<input type="text"/>	No	<input type="text"/>
Eye problems	Yes	<input type="text"/>	No	<input type="text"/>
Heart problems	Yes	<input type="text"/>	No	<input type="text"/>
Diabetic coma	Yes	<input type="text"/>	No	<input type="text"/>
Stroke	Yes	<input type="text"/>	No	<input type="text"/>
Abnormal ECG	Yes	<input type="text"/>	No	<input type="text"/>

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

9. Indicate the following, if applicable:

Last cholesterol level	<input type="text"/> <input type="text"/> <input type="text"/>
Last triglyceride level	<input type="text"/> <input type="text"/> <input type="text"/>
Chest x-ray result	<input type="text" value="Normal"/> <input type="text"/> <input type="text" value="Abnormal"/> <input type="text"/> <input type="text" value="Unknown"/> <input type="text"/>

Provide full details:

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

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
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Momentum 268 West Avenue Centurion 0157
PO Box 7400 Centurion 0046 South Africa
ShareCall 0860 66 23 45
insurancemedicals@momentum.co.za momentum.co.za

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Momentum Metropolitan Namibia Limited
MM House 5th Floor Cnr Dr Frans Indongo & Werner List Street Windhoek
PO Box 3785 Windhoek Namibia
Tel +264 (0)61 297 3000 Fax +264 (0)61 297 3573 service@momentum.com.na

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