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Questionnaire For: Diabetic

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

Agent's Name: _____ Phone #: _____
Proposed Insured: _____ Date of Birth: ___/___/___
Male () Female () Height _____ Weight _____ Smoker () Non Smoker ()
Amount of Coverage \$ _____ Product Type _____

1. Weight two years ago _____
2. Date Diabetes diagnosed _____
3. Are you receiving treatment or under medical supervision? _____
4. Give name and address of doctor _____
5. How do you control your diabetes? [] Diet [] Insulin [] Oral tablets
6. If taking insulin, what type? _____ Number of units daily? _____
Time of administration? _____
7. If taking oral tablets, what type? _____ Amount? _____
Time of administration? _____
8. Have you had any reactions? _____ Comas? _____
Hospitalization? _____
9. Do you ever stop your treatment or go off diet? _____
10. Is urine sugar free? [] Now [] Always [] Date of last test _____
11. Have you had any blood studies done? _____
12. If so, when and what were the fasting values? _____
13. What is the diet at present? Protein _____ gms. Fat _____ gms.
Carbohydrates _____ gms.
14. Have you ever had any infections, such as boils, abscessed teeth, tonsillitis, etc? Specify _____

14. Have you had any eye trouble? _____

15. Have you ever had chest pain, ankle swelling or heart trouble? _____

16. Have you ever had high blood pressure? _____

17. Have you ever had any kidney disorder? _____

18. Have you ever had any recurring or prolonged illness? _____

19. Have you ever had any difficulty with neuritis, pain, or paralysis? _____

20. Has your diabetes been better _____ worse _____ unchanged _____

FAMILY HISTORY

Family Member	Age If Living	State of Health or Cause of Death	Age at Death
Father			
Mother			
Siblings			