United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Diabetic Questionnaire

PLEASE PRINT – Please attach an additional sheet of paper if necessary

1 Name of Proposed Insured ______________________ Date of Birth ____________

2 Height ________ ft. ________ in. Weight ________ lbs. Weight two years ago ________ lbs.

3 When were you first diagnosed with diabetes? Date ____________

Name and address of physician ______________________________

____

4 Are you receiving treatment or are you under supervision now? . . . . ☐ Yes ☐ No

If "Yes,": Date of last visit ____________ Name and address of physician (if different from above) ________

____

5 How are you treating your diabetes?

☐ Diet only

☐ Insulin: Units____________ (per day)

☐ Oral medication: Name and dosage ________________

6 Do you regularly do home glucose monitoring? . . . . ☐ Yes ☐ No

Average range at home?__________

7 When was your last glycohemoglobin (Hemoglobin A1C) test? ______ Result? ____________

Who performed the test? (Full name and address, if different from above) ____________

9 (a) Have you ever been in (ketoacidosis) diabetic coma? ....☐ Yes ☐ No - Number of times? ____ Dates ________

(b) Have you ever had insulin shock (hypoglycemia)? ....☐ Yes ☐ No - Number of times? ____ Dates ________

(c) If 9(a) and/or 9(b) is answered "Yes," please advise the names of the physicians seen and the hospitals used for the most recent episodes of each.______________________________

____

10 Have you ever had or been told you had by a physician or health care provider any of the following? (Please indicate "Yes" or "No")

Changes in vision or retinopathy .... ☐ Yes ☐ No

Hypertension .... ☐ Yes ☐ No

Albumin or protein in urine .... ☐ Yes ☐ No

Heart disease .... ☐ Yes ☐ No

Skin Ulcers .... ☐ Yes ☐ No

Kidney Disease .... ☐ Yes ☐ No

Eye Laser therapy................................ ☐ Yes ☐ No

High cholesterol.................................. ☐ Yes ☐ No

Numbness or neuropathy..................... ☐ Yes ☐ No

Please provide details of any "Yes" answers, including names of physicians and dates: ____________

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11 Have you ever had an abnormal electrocardiogram or stress test? . . . . ☐ Yes ☐ No

If "Yes," please provide date and by whom: ______________________________

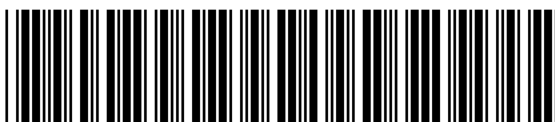
I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

______________________________ ____________

Witnessed Signature of Proposed Insured — Date

______________________________ ____________

Signature of Witness — Date



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