Desjardins Insurance
Life • Health• Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Life Insured Diabetes Questionnaire

Reset Print

To be completed by life insured

First name and last name	Date of birth (yyyy/mm/dd)	Reference number: Case ID, Policy no., Contract no. or Application no.

Occupation	Present height	Present weight	Weight 2 years ago

Date diabetes diagnosed	Name and address of physician who made diagnosis

Name and address of attending physician

How often do you visit your physician?	Date of last visit

Do any family members have diabetes?

☐ Yes ☐ No If **yes,** indicate: ☐ Parents ☐ Brother(s) ☐ Sister(s) ☐ Children

Treatment Used

☐ Diet alone ☐ Diet and oral medication ☐ Diet and insulin

Oral medication used (if any)	Is it taken regularly? ☐ Yes ☐ No	Any change in medication in the last 2 years? ☐ Yes ☐ No

Do you use insulin?

☐ Yes ☐ No If **yes,** indicate frequency:

Has your insulin dose or type changed in the last 2 years?

☐ Yes ☐ No

Do you regularly test your blood?	Blood sugar readings
☐ Yes ☐ No If **yes,** indicate frequency:	Fasting: 2 hours after eating:

Have you had an electrocardiogram or X-ray taken?

☐ Yes ☐ No If **yes,** give results:

Have you ever had:

Diabetic coma	☐ Yes	☐ No	Insulin shock	☐ Yes	☐ No
Kidney impairment	☐ Yes	☐ No	Recurring infection	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Heart impairment	☐ Yes	☐ No
Neuritis	☐ Yes	☐ No	Eye impairment	☐ Yes	☐ No

If Yes, indicate condition(s) and give details.

I declare that the answers given in this document are true and complete and I agree that they form an integral part of my application for insurance.

Date (yyyy/mm/dd)

X _____
Signature of proposed insured
(signature of father, mother or legal guardian, if minor)

X _____
Signature of witness