BB&G © QUICK QUOTE FOR DIABETES

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.

CLIENT: NAME _____ / [ ] M [ ] F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMNT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS.: [ ] PERM [ ] TERM YRS. LEVEL _____

TOBACCO USE: [ ] NO [ ] YES, DETAIL _____ / REPLACEMENT? [ ] YES [ ] NO / CURRENT ANN. PREMIUM $ _____

LAST LIFE INSURANCE APP.: YEAR _____ COMPANY _____ ACTION _____

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. CLIENT'S AGE AT ONSET OF DIABETES _____

2. WHAT IS THE METHOD OF CONTROL?

[ ] DIET ONLY
[ ] DIET AND ORAL MEDICATION(S)*
[ ] DIET AND INSULIN INJECTION
*LIST MEDICATIONS: _____

3. HOW MANY TIMES A DAY IS CLIENT'S INSULIN ADMINISTERED?

[ ] ONE OR TWO TIMES PER DAY
[ ] THREE OR MORE TIMES PER DAY
[ ] INSULIN PUMP

4. HOW OFTEN ARE CLIENT'S BLOOD SUGAR LEVELS MONITORED?

[ ] ONE OR TWO TIMES PER DAY
[ ] THREE OR MORE TIMES PER DAY

5. PLEASE INDICATE ANY OF THE FOLLOWING EXPERIENCED:

[ ] EKG ABNORMALITIES
[ ] INSULIN REACTIONS
[ ] DIABETIC COMA
[ ] EYE TROUBLE
[ ] HEART TROUBLE
[ ] PROTEIN IN URINE
[ ] SKIN ULCERATION
[ ] AMPUTATIONS
[ ] NEUROPATHY OR LOSS OF FEELING

6. PLEASE DETAIL ANY INDICATIONS FROM QUESTION #5, SUCH AS: TYPE OF; DATE OF; FREQUENCY OF OCCURRENCE:

_____

_____

_____

_____

_____

7. HAS THE CLIENT HAD A GLYCOHEMOGLOBIN (A1C) TEST DURING THE PAST SIX MONTHS?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL LEVEL:

[ ] BELOW 7.5
[ ] 7.6 TO 10
[ ] 10.1 TO 13
[ ] ABOVE 13

8. HOW LONG HAS THE GLYCOHEMOGLOBIN LEVEL REMAINED CONSTANT?

[ ] 0 TO 6 MONTHS
[ ] 6 TO 12 MONTHS
[ ] OVER A YEAR

9. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

[ ] 0 TO 6 MONTHS AGO
[ ] 6 TO 12 MONTHS AGO
[ ] OVER 1 YEAR AGO

10. LIST THE LAST CHOLESTEROL READING:

_____ HDL RATIO _____

11. LIST THE LAST BLOOD PRESSURE READING:

_____ SYSTOLIC/ _____ DIASTOLIC

12. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

13. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

14. CLIENT'S OCCUPATION _____

15. PLEASE LIST ANY OTHER ILLNESSES OR IMPAIRMENTS; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

_____

_____

_____

_____

_____