

**American Life Insurance Company**  
 Narayani Complex, Pulchowk,  
 P. O. Box: 11590, Kathmandu, Nepal,  
 Tel.: 5-555166, Fax: 5-555173

## Diabetes mellitus questionnaire-Applicant

**Full Name:** ..... **Application/Policy No.:** .....

- 1 Which type and when was diabetes mellitus first diagnosed?  
 \_\_\_\_\_
- 2 Regarding your treatment: YES/NO  
 a) Do you take oral medication?  
 If yes, please state the type of medication(s) and dosage(s), Including number of times used daily  
 \_\_\_\_\_
- b) Do you use insulin? YES/NO  
 Is Yes, please state the type of insulin and dosage, including Number of times used daily.  
 \_\_\_\_\_
3. Regarding the monitoring of your condition.  
 a.) How often do you test your blood and urine for glucose?  
 b.) Please indicate the last 3 results from the blood glucose test / urine glucose/ HbA1c.
- | Glucose Urine Result | Date | Glucose Blood Result | Date | HbA1C Result | Date |
|----------------------|------|----------------------|------|--------------|------|
|                      |      |                      |      |              |      |
|                      |      |                      |      |              |      |
|                      |      |                      |      |              |      |
- c.) How often do you attend a clinic or doctor for monitoring?  
 d.) When was your last consultation?  
 e.) Please provide the name and address of the clinic or doctor supervising your treatment.  
 \_\_\_\_\_
- 4 Since your treatment begin, have you ever been hospitalized for a Diabetic (hypoglycemic/hyperglycemic) coma or any condition related to diabetes mellitus? If yes, please provide dates. YES/NO  
 \_\_\_\_\_
- 5 Have you ever had any of the following?  
 a.) Protein or albumin in the urine YES/NO  
 b.) Problems with your eyes YES/NO  
 c.) Numbness or tingling in your arms, hands, feet or legs YES/NO  
 d.) High blood pressure YES/NO  
 e.) Heart or circulatory problems YES/NO  
 f.) Problems with your kidneys YES/NO  
 If yes to any, please provide full details.  
 \_\_\_\_\_
- 6 Have you ever been hospitalized or been absent from your work for long time due to this condition YES/NO  
 If yes, please provide full details  
 \_\_\_\_\_
- 7 Please provide any additional information on your condition, which you think may be helpful in Processing your application.  
 \_\_\_\_\_

**I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.**

**I agree that this form will constitute part of my application for life assurance and that failure to disclose any material fact known to me may invalidate the contract.**

\_\_\_\_\_  
**Signature of applicant**

\_\_\_\_\_  
**Date**

**Note: Please attached all treatment related papers with all investigations and Follow ups.**