RBC Insurance

DIABETES QUESTIONNAIRE –
TO BE COMPLETED BY THE PROPOSED INSURED

Name of Proposed Insured: _____ **Application/Policy No:** _____

1. a) At what age did you develop symptoms of diabetes: _____
   b) Date of diagnosis: _____

2. Please provide full details of your present treatment:
   - ☐ Diet and exercise only _____
   - ☐ Oral Medication (type and dosage): _____
   - ☐ Insulin (type and number of units per day): _____
   - ☐ Insulin Pump (type of insulin and number of units per day): _____

3. Has there been any change in treatment in the last 24 months? . . . . . Yes ☐ No ☐
   If yes, provide full details: _____

4. Has your weight changed in the past 24 months? . . . . . Yes ☐ No ☐
   If yes: Weight 12 months ago: _____ Weight 24 months ago: _____

5. Have you ever had:

a)	high blood pressure?	Yes ☐	No ☐	g)	eye or vision problems?	Yes ☐	No ☐
b)	elevated cholesterol levels?	Yes ☐	No ☐	h)	albumin or protein in your urine?	Yes ☐	No ☐
c)	an insulin reaction?	Yes ☐	No ☐	i)	kidney problems?	Yes ☐	No ☐
d)	heart trouble?	Yes ☐	No ☐	j)	numbness or tingling in your limbs?	Yes ☐	No ☐
e)	circulatory problems?	Yes ☐	No ☐	k)	a diabetic coma?	Yes ☐	No ☐
f)	a foot infection?	Yes ☐	No ☐	l)	an amputation?	Yes ☐	No ☐

   If yes, provide full details, including dates:

6. Have you ever had a chest x-ray, an electrocardiogram or other cardiac evaluation? . . . . . Yes ☐ No ☐
   If yes, specify and provide dates and results: _____

7. a) How often do you test your blood sugar level? _____
   b) Is your blood sugar level in a range acceptable to your doctor? _____
   c) What is your usual blood glucose reading? _____
   d) Date and results of your last Hgb A1c test: _____
   e) When your blood sugar is elevated, do you adjust your medication? _____

8. Have you ever consulted an emergency room or been hospitalized because of diabetes or any related condition? . . . . . Yes ☐ No ☐
   If yes, advise date(s), reason(s) and name and address of hospital(s):

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9. Are you followed by your family physician on a regular basis for your diabetes? . . . . . Yes ☐ No ☐

If yes, specify frequency of follow-up visits and date of last consultation:

10. Are you followed by an ophthalmologist or an optometrist on a regular basis? . . . . . Yes ☐ No ☐

If yes, provide name and address of doctor, frequency of follow-up visits and date of last consultation:

11. Have you been referred to a specialist for your diabetes? . . . . . Yes ☐ No ☐

If yes, provide full name(s) and address(es) of specialist(s) consulted, frequency of follow-up visits and date of last consultation:

12. Have you ever lost any time from work due to diabetes or any related complications? . . . . . Yes ☐ No ☐

If yes, provide details including dates and duration of time off work:

13. Have your job duties or daily activities ever been restricted or modified in any way because of this condition? . . . . . Yes ☐ No ☐

If yes, describe restrictions, modifications or limitations:

14. Other than those already declared, please provide the full names and addresses of all doctors, health care professionals, hospitals or health care facilities consulted for this condition and the dates of consultations:

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: **Date** (DD/MM/YYYY):