Hyperclycemia Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information				
1	Date of first Diagnosis		Is condition controlled?	☐ Yes ☐ No
2	What were the last 4 levels for:	Glycohemoglobin:		
		Glucose:		
		Microalbumin		
3	List current medications (accurate name, dosage and reason)			
4	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:	