MILNER
FINANCIAL
AN INTEGRITY COMPANY

DIABETES

Agent Name: ________________________ Agent Phone: _______________ Agent Email: ________________________

CLIENT NAME: ____ **Date:** ________________

☐ Male ☐ Female Date of birth: ____________ Height: ____' ____" Weight: ___________

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: ____________ ☐ Use now Type of nicotine product: _____________

Type of Coverage: ☐ Term ☐ UL ☐ Survivor |

Coverage Amount: ____________________ **Anticipated Premium:** ____________________

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

If yes, use below to provide details

	Age, Living	Age, Death/Reason	Medical hx, age of onset
Father			
Mother			
Sibling(s)			

1. Type I ☐ Type II ☐ Date first diagnosed: _______________

2. How often does your client visit his/her physician?: ____

   When was the last visit? ______________________________

3. The client's diabetes is controlled by:

☐ Diet alone
☐ Oral medication (medication and doses) ______________________________
☐ Insulin - injection (amount and units/day) ______________________________

4. Does client monitor his/her own blood sugar? ________________

5. If available, please give the most recent A1C reading and date: ____

6. Please check if your client has (had) any of the following:

☐ Chest pain or coronary artery disease ☐ Protein in the urine ☐ Elevated Cholesterol
☐ Overweight ☐ Neuropathy (feet) ☐ Kidney disease
☐ Retinopathy (eyes) ☐ Abnormal ECG ☐ Hypertension

7. Is client on any medications now? (Name, dosage, and reason)

Name of Medication	Dosage	Reason

8. Does client have any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

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The above information is for preliminary underwriting purposes only and will not be made part of any contract.