DIABETIC QUESTIONNAIRE

(To be completed by the Life to be Insured)

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health (Fiji) Limited, Level 5, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

	Full Name:		Date of Birth:	
	Proposal Number:		Dated:	
1	Please state your current:			
	Height:	Inches/cm:	Weight:	Pounds/kg:
2	When your diabetes was first diagnosed?			
3	If you attend a diabetic clinic, please give:			
	Name and Address of clinic:			
	Date of last attendance:			
4	Are you now having oral drug treatment? ☐ No ☐ Yes			
	▸ If so, please give name of the drug and the required dosage.			
5	Are you now taking insulin: ☐ No ☐ Yes			
6	Has your intake of insulin or oral drugs varied during the last 2 years? ▸ If so, please give full details.			
7	Please give the dates and results of your last HbA1c (glycated haemoglobin)?			
	Date:		Result:	
	Date:		Result:	
	Please give as much information as possible if your cannot remember your dates or results, please contact your doctor or Diabetes Clinic as this will help in the assessment of your application.			
	If unable to give your last two HbA1c results, please enter “not tested” and answer question 8 below.			
8	How often do you test your blood or urine or glucose?			
	Please indicate your usual test results. If you do not routinely test your urine, please ignore question 8 b).			
	Please tick more than one box if this would give a more accurate reflection of the range of your results.			
	(a) Average pre-breakfast blood glucose. Less than 8.0 9.1 – 11.0	8.1 – 9.0 11.1 or more		
	(b) Urine Glucose negative Glucose ++	Glucose + Glucose +++ or more		
9	Since your treatment began, have you ever had a diabetic (hyperglycaemic) or insulin (hypoglycaemic) coma requiring the assistance of another person, hospital admission or intravenous glucose. ☐ No ☐ Yes			
	If so, please give details including dates.			

10	Have you ever had:		
	(a) Problems with your eyes?	☐ No	☐ Yes
	(b) High Blood Pressure?	☐ No	☐ Yes
	(c) Heart or circulatory trouble?	☐ No	☐ Yes
	(d) Albumin or protein in your urine?	☐ No	☐ Yes
	(e) Numbness or tingling in your feet or legs?	☐ No	☐ Yes

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 proposal.

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

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: