STAMM UNDERWRITING SUPPORT

Underwriting Support

Diabetes

Please answer each question completely and provide as much detail as possible.

Producer Name: _____ Phone: _____ Date _____

Client Name: _____ Date of Birth: _____ Gender: _____

Coverage Type: ☐ Whole Life ☐ Term ☐ Universal Life Face Amount: _____ Max Premium: _____

Please provide details of policy design requests and/or any benefit riders requested: _____

_____

Does the client current currently smoke cigarettes?

☐ Yes ☐ No

Does the client currently use any other form of tobacco products (i.e. nicotine patch, snuff, pipe, cigars, chew, Nicorette gum, etc.?)

☐ Yes ☐ No

If yes, please provide details: _____

DIABETES HISTORY

Date of diagnosis: _____ Age at onset: _____

Date of most recent A1C test:_____ A1C reading: _____

_____

How often is the client seen by their physician for diabetic follow up/check-up visits? (i.e. monthly, every six months, annually, etc.) _____

Is the client treated with insulin? ☐ Yes ☐ No

Total Amount of Insulin Units: _____

Is the client treated with oral medication? ☐ Yes ☐ No

If yes, please provide details: _____

Please provide the name, dosage and frequency of any medication treatment: _____

_____

_____

Please provide the details of any/all other treatments the client uses to control their diabetes (I.E. dietary regimen, structure weight loss plan, etc.) _____

_____

_____

Recent physical findings *(please complete in as much accurate detail as possible)*

Blood Pressure: _____ Treated with medication? ☐ Y ☐ N Details: _____

Cholesterol: _____ Treated with medication? ☐ Y ☐ N Details: _____

Height: _____ Weight: _____ Weight loss in last 12 months? ☐ Y ☐ N Details: _____

If there has been a weight change, please provide the reason and any other pertinent details: _____

_____

_____

Has the client ever experienced any of the following? (*If yes, please provide details in the space provided below*)

☐ Weight problems	☐ High blood pressure	☐ Chest Pain	☐ Insulin shock
☐ Coronary artery disease	☐ Abnormal ECG/EKG	☐ Elevated Lipids	☐ Diabetic coma
☐ Neuropathy	☐ Retinopathy	☐ Kidney Disease	☐ Alcohol/drug abuse
☐ Protein in the urine	☐ Albuminuria	☐ Glycosuria	☐ Other

Please provide the details of any items marked yes: _____

_____

_____

_____

_____

In the area below, please provide any additional details pertinent to your client's medical/personal history and his or her alcohol use history: