Colonial Life Insurance Company (Trinidad) Limited

29 ST VINCENT STREET
PORT OF SPAIN

UNDERWRITING
DIABETIC QUESTIONNAIRE (INSURED)

NAME:

DATE OF BIRTH: **POLICY #:**

(1) Please give the name and address of the doctor or clinic supervising your treatment……

……..……

(2) When was your diabetes diagnosed?……..

(3) What is your diet? PROTEINS……..gms. FATS……gms.

CARBOHYDRATES……..gms.

(4) Are you now taking insulin? [ ] YES [ ] NO

If so, state the number of units:-

Plain (Soluble)…….units per day

Protamine Zinc or Ultra-Lente...…….units per day

Globin, N.P.H. Lente or Semi-Lente……...units per day

(5) If you are having oral treatment, state the type of drug and the dosage……...

……...and if so,

give details of previous dosage……

(6) Have you, since your treatment began, stopped taking insulin or reverted to an unrestricted diet?
[ ] YES [ ] NO

(7) Is your urine sugar free:-
Now? [ ] YES [ ] NO
Always? [ ] YES [ ] NO

(8) Since your treatment began, have you ever had a diabetic or insulin coma?
[ ] YES [ ] NO

If so, please give details……...

I agree that the above questions and answers shall form part of my proposal for life insurance.

_____ _____

SIGNATURE **DATE**