

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