Diabetic

Supplementary questionnaire (to be completed by the life to be insured)

Instructions

Please complete this form to supplement the answers you have given on your proposal. The information you give may assist us in the assessment of your proposal and help minimise the need for medical reports.

Please complete this form in **CAPITAL** letters. All questions must be answered accurately with full disclosure of all relevant information.

If there is insufficient space for any answer, please continue on a separate piece of paper and attach to this questionnaire.

1 Personal details

Full name of life to be insured

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please give details) _____

Family name _____

Forename(s) _____

Date of birth D D M M Y Y Y Y

Proposal number _____

2 Supplementary questions

Date diabetes diagnosed. Date D D M M Y Y Y Y

Name and address of the doctor or clinic now treating you.

_____

Please state the frequency of your visits.

_____

Date of last attendance. Date D D M M Y Y Y Y

Do you follow a strict diet? ☐ Yes ☐ No

Are you taking insulin? ☐ Yes ☐ No

If 'Yes' please state the type, dosage and the date insulin was first prescribed.

Name of insulin _____ Dosage _____

Date first prescribed. Date D D M M Y Y Y Y

Supplementary questions (continued)

If you are having oral treatment, please state the type of drug(s), the dosage and the date it was first prescribed.

Drug(s) _____ Dosage _____

Date first prescribed. Date D D M M Y Y Y Y

Has your intake of insulin or oral drug(s) varied during the last two year(s)? ☐ Yes ☐ No

If 'Yes' please give details of previous dosage.

Have you, since your treatment began, stopped taking insulin or reverted to an unrestricted diet? ☐ Yes ☐ No

Do you take any other medication ☐ Yes ☐ No

Please give details of medicines and dosage

Medicines _____ Dosage _____

Have you ever been treated as an in-patient due to your diabetes? ☐ Yes ☐ No

Do you test your own urine and blood sugar levels? ☐ Yes ☐ No

Please give sample readings over the last three months. **If unknown please state UNKNOWN**.

Urine			**Blood**		
Date	Sugar	Protein	Date	Blood sugar	HbA1c

Since your treatment began, have you ever had a diabetic (hyperglycaemic) or insulin (hypoglycaemic) coma? ☐ Yes ☐ No

If 'Yes' please give details.

Have you ever had:

i. Problems with your vision? ☐ Yes ☐ No

ii. Heart or circulation problems? ☐ Yes ☐ No

iii. High blood pressure? ☐ Yes ☐ No

iv. Loss of feeling, numbness or tingling in feet? ☐ Yes ☐ No

v. Kidney problems? ☐ Yes ☐ No

If 'Yes' please state details, duration and treatment.

Have any of your parents, brothers or sisters suffered or died before age 60 from heart disease, high blood pressure, diabetes or kidney disease? ☐ Yes ☐ No

If 'Yes', please state relationship, cause, age at diagnosis, and if appropriate, age at death.

Supplementary questions (continued)

Do you have any other health problems? ☐ Yes ☐ No

If 'Yes', please provide details below.

Have you ever been off work with this complaint? ☐ Yes ☐ No

If 'Yes', please provide details below.

Have you smoked or used any form of tobacco (eg cigarettes, cigars, pipe or chewing tobacco or shisha) in the last 12 months? ☐ Yes ☐ No

If 'Yes', please give details below.

Are you an ex tobacco user? ☐ Yes ☐ No

If Yes, when did you stop and why?

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3 Privacy notice

The personal information requested in this form is collected and used by Zurich International Life Limited (the Company) as Data Controller in line with the Data Protection Policy. Full details can be found online at https://www.zurichinternational.com/en/zurich-international-life/about-us/privacy or contact us for a copy.

4 Declaration/consent

I declare that the answers given, whether in my handwriting or not, are true and complete to the best of my knowledge and belief. I agree that this form will constitute part of my proposal and that failure to disclose any material fact known to me may constitute grounds for rejection of a claim or repudiation of the contract.

Special category data consent

By signing this form, I consent to the Company processing my medical and health information and authorise the seeking and processing of information from any medical practitioner who has attended me or from any insurer to which an application has been made for insurance. I confirm such authorisation shall remain in force after my death.

Withdrawal of consent

I understand that where I have provided consent I have the right to withdraw the consent at any time and that such withdrawal will not affect the data processing carried out prior to such withdrawal.

If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal.

Signature of life to be insured

Date D D M M Y Y Y Y

MSP13130 (715712004) (08/22) CMS

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