* Q U E S T *

AVIVA

Diabetes Supplementary Questionnaire (Q6I)

Particulars of Life Assured

Name : _____

Identity Card / Passport No. : _____ Contract No. : _____

Medical Questions

1. When was this condition diagnosed?

   _____

2. Please state the diagnosis by the doctor:

   ☐ Insulin Dependent Diabetes Mellitus (IDDM) (Type 1)

   ☐ Non Insulin Dependent Diabetes Mellitus (NIDDM) (Type 2)

   ☐ Impaired Glucose Tolerance

   ☐ Impaired Fasting Glucose

3. What treatment was or has been prescribed by your doctor?

   Please tick accordingly and provide details:

   ☐ **Oral Medication**

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

   ☐ **Insulin**

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

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☐ **Diet control only**

☐ **Others,** please provide details: _____

Please specify date of last treatment (if applicable): _____

4. Have you undergone any investigations?

☐ Yes ☐ No

If '**Yes'**, please provide details:

Type of Investigation / Test	Date	Results*
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal

* For abnormal results, please provide details: _____

_____

5. Please provide your last 3 blood glucose readings:

Date of Test	Blood Glucose Reading

6. Please provide your last 3 urine glucose results in terms of negative, +, ++, +++ or more:

Date of Test	Urine Glucose Reading

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7. Please provide your last 3 HbA1c (glycosylated haemoglobin) test results:

Date of Test	HbA1c Reading

8. Have you ever had a diabetic (hyperglycaemic), insulin (hypoglycaemic) coma or been admitted to hospital due to any other diabetes related condition?

☐ Yes ☐ No

If '**Yes**', please provide details:

_____

9. Have you ever had any of the following?

Please tick accordingly and provide details:

	Yes	No	If 'Yes', please provide details
Problems with your eyes/vision			
High Blood Pressure			
Albumin or protein in your urine			
Heart or circulatory disorder			
Numbness or tingling in your legs			

10. Have you ever taken time off from work or school due to this condition?

☐ Yes ☐ No

If '**Yes**', please provide details:

Date	Duration of Time-off

11. Do you smoke cigarettes or any form of tobacco?

☐ Yes ☐ No

If '**Yes**', please provide details. Number of sticks per day: _____ Number of years: _____

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12. Please provide the name and address of the doctor /clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

Note: Please provide us with copies of all medical reports relating to this condition, if available.

Declaration

I/We agree to inform Aviva Ltd if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Aviva Ltd to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

_____ _____

Name and Signature of Life Assured Date (dd/mm/yyyy)

_____ _____

Name and Signature of Assured Date (dd/mm/yyyy)

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