

# Medical Supplement to Application Diabetes

## INSURER

Fidelity and Guaranty Life Insurance Company    Americom Life and Annuity Insurance Company

First Name

MI

Last Name

1. When was diabetes first diagnosed? \_\_\_\_\_
2. Regarding your treatment:
  - a. Do you take oral medication?  Yes    No  
If YES, please state the name of the tablets: \_\_\_\_\_
  - b. Do you take insulin?    Yes    No  
If YES, please state type of insulin and dosage (including number of times daily): \_\_\_\_\_  
\_\_\_\_\_
  - c. Has your treatment been changed in the last 2 years?    Yes    No  
If YES, please provide full details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Do you follow a strict diet?    Yes    No
4. Regarding the monitoring of your condition:
  - a. Please provide the name and address of the doctor or clinic supervising your treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - b. How often do you attend for monitoring? \_\_\_\_\_
  - c. When was your last consultation? \_\_\_\_\_
  - d. How often do you test your blood or urine for glucose? \_\_\_\_\_
  - e. Please indicate your usual blood glucose reading:  
 Blood Glucose:    Below 145    146-165    166-200    Over 200  
 Urine Glucose:    Negative    +    ++    +++ or more
  - f. Please provide the dates and results of your last two HbA1c (glycosylated hemoglobin) tests, if known: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Since your treatment began, have you ever had a diabetic (hyperglycemic) or insulin (hypoglycemic) coma?    Yes    No  
If YES, please provide full details, including date(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(continued)*

## Medical Supplement to Application – Diabetes (continued)

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6. Have you ever had any of the following:

- a. Problems with your eyes?  Yes  No
- b. High blood pressure?  Yes  No
- c. Heart or circulatory trouble?  Yes  No
- d. Albumin or protein in your urine?  Yes  No
- e. Numbness or tingling in your feet or legs?  Yes  No

If YES to any of the above, please provide full details: \_\_\_\_\_

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7. Have you lost time from work due to diabetes or associated conditions?  Yes  No

If YES, please provide details including dates and duration of time off work: \_\_\_\_\_

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8. Please provide any additional information on your condition which you feel will be helpful in processing your application: \_\_\_\_\_

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I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for life insurance and that failure to disclose any material fact known to me may invalidate the contract.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date