

Fast Track Underwriting - Customer Medical Questionnaire

Diabetes

Name of customer applying for cover



Date of birth

Application number

Financial adviser

Guide to filling in this questionnaire

1 Make sure you fill in the customer details above.



2 You should read the **important note** below about telling us about material facts.



3 Please complete the questionnaire, providing as much details as possible about your medical history.



4 Read through the answers you have given and the declaration and sign it, on the last page of this form.

Important note – Telling us about material facts

Please read the information below carefully – ask your financial adviser if you have any questions.

- You must tell us everything relevant when filling in this questionnaire. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A relevant fact (material fact) includes anything that a reputable insurer would treat as likely to influence their decision to provide insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the "further medical information" section.
- We will rely on what you tell us and you must not assume that we will automatically confirm with your GP or any other doctor any information that you provide. If relevant, you can consult your GP about the questions on this form, but we cannot cover the cost of your doctors time. You can provide any highly confidential information direct to our Chief Medical Officer in a sealed envelope and give this to your financial adviser. In these circumstances you must refer to this information when answering your health questions.
- You do not need to tell us about any genetic test (that is, analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. However, you must tell us if you are having treatment for or experiencing symptoms of a genetic condition. We may also ask you to give us full information about your family history, including all genetic conditions.
- You must tell us in writing about any change in your personal medical circumstances or family history or dangerous pursuits you take part in between the time you apply for cover and the time cover begins.



Irish Life

Diabetes

1 Please give your age and date when you were diagnosed with diabetes. Age Date of diagnosis

- 2 Please confirm the type of diabetes you have.
- **Type I** diabetes mellitus (also known as juvenile onset or insulin-dependent diabetes mellitus)
 - **Type II** diabetes mellitus (also known as maturity onset or non insulin-dependent diabetes mellitus)
 - **Gestational** diabetes (during pregnancy) (Please see question 13)

3 Are you now taking insulin? Yes No
If 'Yes', please give the following details.

Long-acting insulin:

Name :
Morning units
Afternoon units
Evening units

Short-acting insulin:

Name :
Morning units
Afternoon units
Evening units

Please confirm the date you started taking insulin.

4 If you are taking diabetic drugs (tablets), please tell us the type and dose each day.

Type	<input type="text"/>	Dose used each day	<input type="text"/>
	<input type="text"/>		<input type="text"/>

5 How often do you test your blood or urine to monitor sugar levels?

Blood	<input type="text"/>	Sample fasting glucometer readings over last two to three months	<input type="text"/>
Urine	<input type="text"/>	Sample readings over last two to three months	<input type="text"/>

Please give the date and result of your most recent HbA1c reading, if you know it.

Date Result % Unknown

How often do you have low blood sugars (hypoglycaemia)?

Do you feel symptoms with low blood sugars? Yes No If 'Yes', please give details.

6 Do you visit your doctor or clinic regularly about your diabetes? Yes No

How often do you visit the doctor? Date of last visit

How often do you visit the diabetic clinic? Date of last visit

7 Have you ever been admitted to hospital to control your blood sugars or had a hypoglycaemic coma or diabetic ketoacidosis?

Yes No If 'Yes', please give full details including dates.

Dates	Details
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>

8 Have you ever been told that your urine contains albumin or protein or that you had other kidney abnormalities? Yes No
If 'Yes', please give full details including the nature of the problem and dates.

Dates	Nature of the problem
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>
<input type="text" value="dd / mm / yyyy"/>	<input type="text"/>

Diabetes

9 Have you ever had any problems with:

- your heart? Yes No or have you ever had an ECG or an exercise/treadmill stress test? Yes No
- the blood vessels in your legs? Yes No
- your eyes? Yes No
- If 'Yes', have you ever needed laser surgery? Yes No Date of your last diabetic eye check
- raised cholesterol? Yes No
- numbness, tingling or any other neurological symptoms? Yes No
- your skin? Yes No
- your feet (for example, foot ulcers or sores, extended healing time for cuts, pains in your calves, heels or feet)? Yes No

If you have answered 'Yes' to any of the questions above, please give full details here.

10 Do you smoke tobacco or have you ever smoked? Yes No If 'Yes', please give full details, including the year you started smoking, the year you stopped (if this applies) and how much tobacco you smoke each day .

Year you started smoking Year you stopped smoking (if this applies)
 How much tobacco do you currently smoke, or used to smoke if now stopped a day
 (number of cigarettes, cigars or ounces of tobacco)?

11 What has your GP or specialist told you about whether your condition is under control or not?

Details

12 Were you ever given any specific health advice or suggested lifestyle changes by any health professional about this condition?

Yes No If 'Yes', please give details.

13 For gestational (pregnancy) diabetes only

- When did you first get gestational diabetes?
- What treatment did you have for it?

• Did you have follow-up blood glucose tests after you had your baby? Yes No If 'Yes', please give dates and results.

Dates	Results
<input style="width: 100px;" type="text" value="dd / mm / yyyy"/>	<input style="width: 500px;" type="text"/>
<input style="width: 100px;" type="text" value="dd / mm / yyyy"/>	<input style="width: 500px;" type="text"/>
<input style="width: 100px;" type="text" value="dd / mm / yyyy"/>	<input style="width: 500px;" type="text"/>

• What did your doctor or specialist tell you about your gestational diabetes and how to manage it?

• Did you have gestational diabetes in more than one pregnancy? Yes No If 'Yes', please give full details.

14 Do any of your immediate family (mother, father, brothers, sisters) suffer from any of the following before age 60 – diabetes, raised blood pressure, raised cholesterol, heart disease, angina, heart attack, bypass surgery, angioplasty or stroke?

Yes No If 'Yes', please list all the relatives affected, their age at diagnosis, their age now or age when they died (if this applies) and condition suffered.

Relative	<input style="width: 150px;" type="text"/>
Condition	<input style="width: 150px;" type="text"/>
Age when diagnosed	<input style="width: 150px;" type="text"/>
Age now	<input style="width: 150px;" type="text"/> or age when died <input style="width: 100px;" type="text"/>

15 Please provide any other information about this condition which you feel may help us assess your application for cover.

Doctors and specialists you have seen

Please fill in the name and address of doctors and specialists you have seen.

Names

1

2

3

Addresses

1

2

3

Further medical information

Please use this space if you need more space to fill in your answers.

Declaration

Please review the answers given in this questionnaire and then read, sign and date this declaration.

I agree that this questionnaire will form part of my application for cover to Irish Life Assurance plc.

I have read and understood the note on the first page of this form about telling Irish Life about material facts and I understand that if I do not reveal all these facts, Irish Life could treat the plan as void and in these circumstances Irish Life will not pay a claim or refund my payments.

I have read over the answers to all the questions on this form and declare that all statements (including any statements written down for me) are true and complete. I understand a copy of this form is available to me if I ask.

I understand that this cover will not start until you have accepted me for cover and I have paid the first premium.

I understand that I must tell you in writing about any changes in my personal medical circumstances, family history or taking part in dangerous pursuits before this cover starts.

Your signature

Date

