

**TO BE
 COMPLETED
 BY THE
 PROPOSED
 INSURED**

Name		Date of birth
Address		
Height	Weight	Weight 2 years ago
Date of original diagnosis		
Name and address of physician who made the diagnosis.		
Are you presently under medical supervision or receiving treatment?		<input type="checkbox"/> no <input type="checkbox"/> yes Please provide details.
Name and address of attending physician or clinic where treatment received.		
Have you ever ceased insulin treatment or resumed an unrestricted diet?		<input type="checkbox"/> no <input type="checkbox"/> yes Please provide details.
Results of blood sugar estimations.		
Results of blood sugar readings for the last 7 days.		
State amount and type of insulin taken daily (or state the daily dose of tablets if oral treatment employed).		
What was your last Glycosolated Haemoglobin and when?		
Have you ever had any of the following:		Please provide details.
Diabetic coma?	<input type="checkbox"/> no <input type="checkbox"/> yes	
Eye trouble?	<input type="checkbox"/> no <input type="checkbox"/> yes	
Heart trouble?	<input type="checkbox"/> no <input type="checkbox"/> yes	
High blood pressure?	<input type="checkbox"/> no <input type="checkbox"/> yes	
Recurring or prolonged illness?	<input type="checkbox"/> no <input type="checkbox"/> yes	
Trouble with the circulation to your feet or legs?	<input type="checkbox"/> no <input type="checkbox"/> yes	

Has albumin ever been found in your urine?	<input type="checkbox"/> no	<input type="checkbox"/> yes Please provide details.
Has your creatinine ever been found elevated?	<input type="checkbox"/> no	<input type="checkbox"/> yes Please provide details.
Has an electrocardiogram been taken?	<input type="checkbox"/> no	<input type="checkbox"/> yes Please provide details.

**BROKER
INFORMATION**

 Broker/Agent/Consultant

 Contact name and telephone no.

DECLARATION

I agree that the above questions and answers shall form part of my proposal for insurance and I authorize WILLIAM J. SUTTON & CO. LTD. to approach the physicians named to confirm the details of my medical history.

 Signature

 Date