

First and last names of insured: \_\_\_\_\_

Y | Y | Y | Y | M | M | D | D |

Date of birth

Policy/application number

1. a) What is the date of diagnosis: Y | Y | Y | Y | M | M | D | D |

b) What is the type:

Type 1  Type 2

Gestational

Are you pregnant? If yes, specify the expected delivery date: Y | Y | Y | Y | M | M | D | D |

If no, specify the last delivery date: Y | Y | Y | Y | M | M | D | D |

2. What treatment were you prescribed?

Diet

Oral medications specify: name \_\_\_\_\_ and dosage: \_\_\_\_\_

Date of last use: Y | Y | Y | Y | M | M | D | D |

Insulin specify: name \_\_\_\_\_ and number of units per day: \_\_\_\_\_

Date of last use: Y | Y | Y | Y | M | M | D | D |

3. Do you use a blood glucose meter?  Yes  No

If yes, specify the frequency of use: \_\_\_\_\_ Average value of your blood glucose in the last month: \_\_\_\_\_

If no, specify the last blood test date: Y | Y | Y | Y | M | M | D | D | Level of glycated haemoglobin (HgbA1c): \_\_\_\_\_

4. Do you suffer from complications related to your condition?  Yes  No

If yes, specify:

Eye disorders (decreased or loss of vision, retinopathy, etc.)

Kidney disorders (nephropathy, renal failure, urine abnormalities, etc.)

Cardiovascular disorders

Circulation disorders, loss of sensation, numbness or tingling in the limbs

5. a) Have you ever had episodes of diabetic coma?  Yes  No

If yes, specify date of episodes: \_\_\_\_\_

b) Have you ever had episodes of hypoglycemia?  Yes  No

If yes, specify date of episodes: \_\_\_\_\_

6. Have you ever been hospitalized due to diabetes?  Yes  No

If yes, specify dates: \_\_\_\_\_

7. Have you had to take time off due to diabetes?  Yes  No

If yes, specify date and length of each work interruption: \_\_\_\_\_

8. Please indicate the name and address of the doctors and/or specialists consulted for this condition. If none, check this box:  None

Name	Address	Frequency of consultations	Date of last consultation

9. Additional information:

\_\_\_\_\_

10. Declaration

I acknowledge having fully understood all of the questions above and that the answers given are true and complete. In addition, I consent to having them as an integral part of the requested insurance policy.

**X**

Signature of insured (signature of the father, mother or legal guardian if the insured is a minor)

Y | Y | Y | Y | M | M | D | D |

Date of signature

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