

Trustmark Insurance Company Medical Questionnaire  
PO Box 7930, Lake Forest, IL. 60045  
Phone (800) 229-4543 Fax (847) 615-4954

Diabetes Questionnaire

Proposed Insured:

Address:

Home Phone:

Work Phone:

Birthdate:

Employee:

Employer:

Cert.#:

1. Name, address and phone number of your doctor: \_\_\_\_\_  
\_\_\_\_\_
2. Date last seen prior to **application sign date** : \_\_\_\_\_
3. Current height and weight: \_\_\_\_\_
4. List all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_
5. List all conditions for which you are currently seeing a doctor: \_\_\_\_\_  
\_\_\_\_\_
6. Latest blood sugar or urinalysis reading: Fasting blood glucose: \_\_\_\_\_ (mg/dl) Date: \_\_\_\_\_  
Date: \_\_\_\_\_ Random blood glucose \_\_\_\_\_ (mg/dl) Date: \_\_\_\_\_
7. Please give your date of onset: \_\_\_\_\_
8. Have you had any complications? \_\_\_\_\_  
\_\_\_\_\_
9. Are you insulin dependent? \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date