

**To be completed by Life Insured**

Name of Life Insured			Policy No.		
Occupation		Present Height	Present Weight	Weight 2 Years Ago	
Date Diabetes Diagnosed		Name and Address of Physician who Made Diagnosis			
Name and Address of Present Physician					
How often do you visit your physician?			Date of Last Visit		
Do any family members have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No    If 'Yes', indicate: <input type="checkbox"/> Parents <input type="checkbox"/> Brother(s) <input type="checkbox"/> Sister(s) <input type="checkbox"/> Children					
Treatment Used <input type="checkbox"/> Diet Alone <input type="checkbox"/> Diet and Oral Medication <input type="checkbox"/> Diet and Insulin					
Oral Medication Used (if any)		Is it taken regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No		Any change in medication in the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No    If 'Yes', indicate how frequently you use it.			Has your insulin dose or type changed in the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you regularly test your blood? <input type="checkbox"/> Yes <input type="checkbox"/> No    If 'Yes', indicate how frequently.					
Blood Sugar Readings					
Fasting			2 Hours After Eating		
Have you ever had:					
	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Diabetic Coma	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Shock	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Recurring Infection	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Neuritis	<input type="checkbox"/>	<input type="checkbox"/>	Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes', indicate condition(s) and give details.					
Have you had an electrocardiogram or x-ray taken? <input type="checkbox"/> Yes <input type="checkbox"/> No    If 'Yes', give results.					
I understand that the answers provided above are part of a life insurance application submitted to Desjardins Financial Security Life Assurance Company, and will be used to issue my contract. I acknowledge that I have answered these questions personally, and declare that the answers provided are true and complete. I understand that any false or inaccurate answers may result in the cancellation of my contract.					
Dated at _____ this _____ day of _____ year _____					
Signature of Life Insured _____			Signature of Witness _____		
Name of Field Office		Field Office No.	Name of Representative		Rep. Code
Date Sent to H.O.					