



Diabetes Questionnaire

Blue Cross Blue Shield of Georgia, Inc.

Attn: Underwriting Department

P. O. Box 13047

Roanoke, VA 24030

Customer Svc. Phone: 1-800-718-8831

Fax: 1-800-327-9255

Date: _____

Return by: _____

Underwriting Specialist: _____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information regarding the health status of _____. **(You may use additional paper if necessary. All additional sheets must be signed and dated by the applicant). PLEASE INITIAL AND DATE ANY ALTERATIONS.**

1. Date diabetes diagnosed: ____ / ____ / ____

2. Physician supervising the diabetic program:

Name: _____ Address: _____

Phone # _____ Date of last visit? ____ / ____ / ____

3. Has insulin ever been used for treatment? Yes No **If yes**, please list date(s). _____

4. Have oral tablets ever been used for treatment? Yes No **If yes**, please list date(s). _____

5. **List all HbA^{1C}** lab results recorded by your physician within the past 12 months (**Note:** at least one reading must have been within the past 3 months and there must be 90 days between 2 readings; please list dates): _____

6. **Give results of the blood sugar tests made by the physician within the past 12 months.**

Date	Reading	Number of Hours after Eating	Date	Reading	Number of Hours after Eating
1. ____ / ____ / ____	_____	_____	3. ____ / ____ / ____	_____	_____
2. ____ / ____ / ____	_____	_____	4. ____ / ____ / ____	_____	_____

7. Has a diabetic coma ever occurred or has acidosis been severe enough to require hospitalization? Yes No **If yes**, list the date(s). _____

8. Have any of these conditions or symptoms ever been diagnosed?

Elevated blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other prolonged illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
End Stage Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes to any of these conditions, please explain. _____

9. Has the need for a kidney transplant been advised? Yes No

(continued on next page)

An independent licensee of the Blue Cross and Blue Shield Association.

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

Signature of Applicant or Legal Representative

Date ____/____/____
mo. / day / year

Signature of Spouse or Other Adult to be covered
(if applying for coverage)

Date ____/____/____
mo. / day / year