



(To be completed by the applicant)

Name, First name:					
Date (day/month/year):					
This questionnaire will form pa If any questions below are answ where applicable. 1. Please state when diabetes w	wered "Yes", ple	ase supply full d	etails below including dates and names of do	octors and ins	titutions
Type of diabetes?	Type 1	Type 2	Unsure		
(a) Are you under regular			s?		
			ess of doctor		
 2. Treatment: a) Are you following an a No Yes - plex b) Do you take regular ex No Y c) Are you on tablets? No Y d) Are you on insulin? No Y 3. Has your treatment changed No Y 	appropriate diet? ase provide detai xercise? Yes – how freque Yes – please prov Yes – please prov during the last 5 Yes – please prov	nt? ide details ide details ide details	ns and details		
4. Do you perform home blood No Yes – please state	0 0	ts of the last thre	ee blood sugar readings		
5. Have you ever had any of the	0	1 1 7			
Diabetic coma	No	YesYes	Eye trouble	NoNo	YesYes
Insulin shock Heart disease	□ No □ No	□ Yes	High blood pressure Pain or burning of legs and feet	INO No	□ Yes
Kidney disease		□ Yes	Restricted circulation in lower limbs		□ Yes
Infections, e.g. boils		□ Yes	Amputations	I No	□ Yes
and abscesses			Any other complications	No	☐ Yes
Protein in urine	🗖 No	Y es			
If yes, please provide dates,	names and addr	esses of doctors	consulted		
 6. Have you ever been hospital No Yes – plea 7. Have you ever undergone an No Yes – state 	se provide detail y of the followir	ng? Electrocardio	ogram; chest X-ray; lipid profile; glycosylated	l haemoglobii	n(HbA1c)
			of my knowledge, true and I have not ance of this proposal. I agree that this fo		

information that may influence the assessment of acceptance of this proposal. I agree that this form will constitute part of my proposal for health insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signed: _____

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