**Mutual of Omaha Insurance Company**
Long-Term Care Service Office
P.O. Box 64901, St. Paul, MN 55164-0901

# Diabetic Questionnaire

Name of Proposed Insured _____ Date of Birth _____
Please Print

Answers to these questions may impact insurability for Long-Term Care insurance with Mutual of Omaha.

**Section 1**

| | | | |
|---|---|---|---|
| **1** | Have you been a diabetic for 20 years or more? | ☐ Yes | ☐ No |
| **2** | Is your build below the minimum insurable weight, or exceeds the maximum insurable weight, as per Mutual of Omaha's Build Chart? | ☐ Yes | ☐ No |
| **3** | Does your daily insulin use (all types) exceeds 50 units per day? | ☐ Yes | ☐ No |
| **4** | Has your doctor increased your diabetes medication dosage or added or changed medications (unless due to side effects) within the past 6 months? | ☐ Yes | ☐ No |
| **5** | Do your medical records reflect that you may have trouble controlling your diabetes? | ☐ Yes | ☐ No |
| **6** | Do your medical records reflect that you may not have followed by physician's advice regarding your diabetic care? | ☐ Yes | ☐ No |
| **7** | Do you have numbness and or tingling in your toes, feet, legs/extremities (neuropathy or diabetic nerve pain)? | ☐ Yes | ☐ No |
| **8** | Have you been told you have kidney problems or damage related to your diabetes? | ☐ Yes | ☐ No |
| **9** | Have you been told you have eye retinal blood vessel damage (retinopathy) or have had eye laser surgery (other than LASIK)? | ☐ Yes | ☐ No |
| **10** | Do you have a history of leg ulcer(s) or poor wound healing? | ☐ Yes | ☐ No |
| **11** | Have you had a mini stroke (TIA) or stroke? | ☐ Yes | ☐ No |
| **12** | Do you have stent(s) in your neck or leg(s)? | ☐ Yes | ☐ No |
| **13** | Is your Hemoglobin A1c › 8.0? | ☐ Yes | ☐ No |
| **14** | Is your Microalbumin › 20mg/dl, and/or have you been told you have protein in you urine? | ☐ Yes | ☐ No |

If any questions in Section 1 are answered "Yes," do not take the application as we regret we will be unable to offer this client coverage.

**Section 2**

| | | | |
|---|---|---|---|
| **1** | Have you used any form of tobacco (other than up to 1 cigar per month) in the past 12 months? | ☐ Yes | ☐ No |
| **2** | Have you been diagnosed with Chronic Atrial Fibrillation? | ☐ Yes | ☐ No |
| **3** | Have you been diagnosed with Carotid Artery Disease? | ☐ Yes | ☐ No |

If "Yes," provide the artery narrowing/stenosis percentage (example: 50-70%) _____

Yes answers to any of the questions in Section 2 may result in the policy being rated or declined. You may wish to contact our underwriting department before submitting the application. You may call us at 800-551-2059 option 2 or email questions to ltcunderwriting@mutualofomaha.com.



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