AGC HEALTH PLAN
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Diabetic Questionnaire

Claims Administrator:
Consociate•Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: ______________________________

Employee name: ______________________________

Dependent name (if condition is for dependent) ______________________________

Age: __________ Height: __________ Weight: __________

1. When diabetes first diagnosed? ______________ Age at diagnosis? ______________
2. Type of diabetes: ______________________________
3. Do you follow a diabetic diet? ______________________________
4. Are you receiving oral medications or insulin?

Medication name	Dosage	Frequency

5. Do you test your blood sugar yourself? Yes or No If yes, please provide the last 3 readings, including the date and the specific glucose reading:

   1st date ______________ Reading ______________
   2nd date ______________ Reading ______________
   3rd date ______________ Reading ______________
6. If you do not check your own blood sugar, please provide the last two (2) fasting blood sugar results from your Doctor's office, including the date and the specific glucose reading.

   1st date ______________ Reading ______________
   2nd date ______________ Reading ______________
7. Date and reading of Hgb A1C (Glycohemoglobin). This lab result MUST be provided
   If unsure, please call your Doctor to ask: ______________________________
   If you cannot provide this result, you must submit the lab results from your Doctor.
8. Any problems or complications resulting from diabetes? (i.e. neuropathy, gangrene or amputation)? ______________________________
9. Are you currently being treated for any other condition besides diabetes? Yes or No
   If yes, please list: ______________________________

Please be advised that you may be required to submit medical records.

Employee signature: ______________________________ Date: __________