

Please answer all questions fully, giving details if requested.

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Renewal Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

1. Full Name: \_\_\_\_\_

2. Occupation: \_\_\_\_\_

3. Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_

4. Date of onset: \_\_\_ / \_\_\_ / \_\_\_\_\_

5. Height: \_\_\_\_\_

6. Weight \_\_\_\_\_

7. When did you last consult your GP regarding this condition? \_\_\_ / \_\_\_ / \_\_\_\_\_

8. Are you currently being treated or taking prescription medication for this condition? YES  NO

If yes, please provide details  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do you attend a diabetic clinic for regular checks for this condition? YES  NO

If yes, please provide details  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Is your blood glucose stable and in control? YES  NO

If no, please provide full details  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Have you ever had any complications with any of the following? (tick as appropriate)

- |                            |                              |                             |
|----------------------------|------------------------------|-----------------------------|
| a) Eyes                    | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| b) Kidneys                 | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| c) Protein in urine        | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| d) Elevated Blood Pressure | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| e) Heart                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| f) Feet or extremities     | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| g) Neurological            | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If you have answered yes to any of the above, please provide details and relevant dates

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12. Have you ever had an admission to hospital as a result of your diabetes?

YES  NO

If you have answered yes to the above, please provide details and relevant dates

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Additional information:

I hereby declare that to the best of my knowledge and belief the above statements and particulars are true and complete.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**When complete please return this form to Groupama Personal Accident & Travel Underwriting,  
Groupama House 24-26 Minories, London EC3N 1DE Tel (0870) 241 6182 Fax (0207) 264 2864  
pa&travel.underwriting@groupama.co.uk**

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