



Please submit this form and all related correspondent to:

WEA Administrators

2525 Embassy Drive, Suite 15
Cooper City, FL 33026 - USA

Phone 1 (954) 889-2100
Fax 1 (954) 241-2002
Email info@wwexpa.com
URL www.weadirect.com

IMPORTANT: PLEASE READ INSTRUCTIONS CAREFULLY

The requested information is required to consider the following patient for medical coverage.

- Please complete all areas
- Use additional paper, if necessary

Name of Patient

Date of Birth (MM/DD/YY) Height Weight

1. When was diabetes diagnosed?

1. What treatment has been prescribed?

a) Diet only Yes No

b) Oral hypoglycemic (please state drug and dosage)

c) Insulin (please state type and dosage)

3. How well does the patient control his/her condition?

4. Latest Glucose readings: *(All three readings must be completed)*

Date (MM/DD/YY)	<input type="text"/>	Readings	<input type="text"/>
Date (MM/DD/YY)	<input type="text"/>	Readings	<input type="text"/>
Date (MM/DD/YY)	<input type="text"/>	Readings	<input type="text"/>

5. If you are the attending physician, does the proposer attend a diabetic clinic? Yes No

If so, please provide the name and address of clinic, and date of last known attendance.

Clinic's Name

Clinic's Address

6. Have there been any episodes of hypoglycemia requiring intravenous glucose, or hospital admission due to diabetic coma or ketoacidosis? If so, please provide details. Yes No

7. Please provide details of any glycosylated hemoglobin measurements.

8. Is there evidence of any of the following? If YES, please provide details.

a) Retinopathy, Nephropathy, Neuropathy Yes No

b) Ischemic heart disease, Peripheral vascular disease, High Cholesterol or Hypertension Yes No

Name of Physician Date (MM/DD/YY)

Signature of Physician