



## Epilepsy/Seizure Disorder Questionnaire

**Agent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Client:** \_\_\_\_\_ **DOB :** \_\_\_\_\_  *Male*  *Female*  
**Product/Face Amount:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

\* **TOBACCO/NICOTINE USE (past or present):**  **YES\*\*\***  **NO**

\*\*\*Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

\* Date of Diagnosis:

\* Date of Last Seizure:

\* What type of epilepsy or seizure disorder has been diagnosed and/or what terms have been used to describe the character of the epileptic or seizure attacks? IE: grand mal, petit mal, sensory, temporal lobe, psycho-motor, etc.?

\* What types of symptoms accompany the epileptic episodes?

\* How frequent are the epileptic episodes?

\* **MEDICATIONS** - List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

\* Has any surgical procedure been recommended/done to treat the epileptic condition? If so, date of surgery?

\* Does the proposed insured drive?

\* What is the proposed insured's occupation?

\* Does the proposed insured engage in any hazardous activities?

\* **FAMILY HISTORY:** (*Family history may be a factor in determining rate class*) **Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:**

*Cardiac Disease*     YES  NO                      *Diabetes*                       YES  NO  
*Stroke or TIA*         YES  NO                      *Cancer*                       YES  NO

*Please provide details for any "YES" response below (attach additional sheet if necessary)*

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED (list age @ time of death)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

\* **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (*Complete additional questionnaires, as indicated*)

*Condition(s) - List treatment and current status:*

*NONE - NO other medical conditions or health issues.*

\* **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.**

\* **Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**