

Epilepsy or Seizure Disorder Questionnaire

Name Male Female Age _____ Date of Birth _____

Tobacco Use No Cigarettes Other tobacco _____ Date quit? _____

State _____ Amount of Insurance _____ Type of Insurance _____

Occupation/Source of income: _____

1. Type of Seizure Disorder or Epilepsy: Petite Mal, Partial or Focal _____

2. Cause of Seizure disorder: Congenital malformation, Fever or infection as a child, _____

Trauma, Alcohol or drug abuse, Brain Tumor or Stroke (CVA) _____

Other please specify: _____

Cause Unknown, Complete investigation, Negative investigation except some minor EEG abnormalities _____

Incomplete investigation- Details: _____

3. Control: No seizures within 2 or more years, No seizures within past one year _____

Up to 3 seizures within a year, From 3-6 seizures within a year _____

From 6-12 seizures within a year, Over 12 seizures within a year _____

4. Date seizure disorder diagnosed? _____ Date of last seizure: _____

5. Treatment: Medication, please indicate type and amount: _____

Surgery or other treatments- Details: _____ Date: _____

6. How often do you visit a physician? _____

General Questions

1. Do you have any other major health problems? No Yes – Details: _____

2. List all medications: _____

3. Height: _____ Weight : _____ Most recent blood pressure reading: _____

Agent Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance Copyright 2000 to 2004.

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