SEIZURE DISORDER (EPILEPSY)

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of first diagnosis: _____

2. When did client have the first and last seizure? _____

Type of seizures: ☐ grand mal ☐ petit mal ☐ other: _____

3. What was the frequency of the seizures prior to the last one?

_____

4. What type of treatment is indicated? _____

_____

5. When did client last see his/her physician for this condition?

_____

_____\

6. What is client's occupation?

_____

7. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

8. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

9. Are there any of the following avocations (additional questionnaires may be required): ___ No ___ Yes:

___ Piloting an aircraft
___ Racing
___ Scuba diving
___ Mountain climbing
___ Skydiving

