



# 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 **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

### FAMILY HISTORY

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

- Date of first diagnosis: \_\_\_\_\_
- When did client have the first and last attack? \_\_\_\_\_
- Are the attacks  grand mal or  petit mal in character?
- What is the frequency of the attacks? \_\_\_\_\_  
 \_\_\_\_\_
- What type of treatment is indicated? \_\_\_\_\_  
 \_\_\_\_\_
- When did client last see his/her physician for this condition?  
 \_\_\_\_\_  
 \_\_\_\_\_
- What is client's occupation?  
 \_\_\_\_\_  
 \_\_\_\_\_
- Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

- Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details  
 \_\_\_\_\_  
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