Epilepsy / Seizure Disorder Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. What type of epilepsy/seizure disorder does the proposed insured have?

___ Generalized Seizures	Date of diagnosis: _____
___ Sleep Epilepsy	Date of diagnosis: _____
___ Traumatic Epilepsy	Date of diagnosis: _____
___ Television Epilepsy	Date of diagnosis: _____
___ Single "Fit"	Date of diagnosis: _____

2. When was the proposed insured's last seizure? _____

3. What terms have been used to describe the character of the seizures? (Check all that apply.)

___ Grand mal	___ Petit mal	___ Partial seizure	___ Motor
___ Sensory	___ Temporal Lobe	___ Absense attacks	___ Atonic
___ Myoclonus seizures	___ Other: _____		

4. What type of symptoms accompany the episodes? (Check all that apply.)

___ Unconsciousness ___ Uncontrolled twitching ___ Deep sleep

5. How frequent are the seizures? _____

6. Has any surgical procedure been recommended? ___ Yes ___ No
   If yes, provide details: _____
   _____

7. Does the proposed insured drive a car? ___ Yes ___ No

8. Is the proposed insured current taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) _____
   _____
   _____

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