

# 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?

1. Date of first diagnosis: \_\_\_\_\_

1. When did client have the first and last attack? \_\_\_\_\_

2. Are the attacks  grand mal or  petit mal in character?

3. What is the frequency of the attacks? \_\_\_\_\_

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