Epilepsy Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	Date of first Diagnosis		Indicate the number or frequency of episodes and date of last episode
2.	Indicate the type of seizure:		Complex / Partial Seizure
			Tonic-clonic Seizure
			Absense Seizure
			Myoclonic Seizure
3	Has client been hospitalized for treatment of epilepsy?	☐ Yes ☐ No	*If yes, give details, dates and lengths of stay*
4	List current medications (accurate name, dosage and reason)		
5	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:

Don Boozer & Associates
P: 1-800-543-0886
F: 1-888-543-0886