Seizure Disorder Questionnaire

(Epilepsy)

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 attack		Date of last attack	
2	Are the attacks 'grand mal' or 'petit mar' in character?	☐ Grand Mal ☐ Petit Mar	What is the frequency of the attacks?	
3	What type of treatment is indicated?			
4	List current medications (accurate name, dosage and reason)			
5	When did client last see his/her physician for this condition?			
5	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:	