

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: _____

2. Indicate the type of seizure:

Complex/partial seizure Tonic-clonic seizure Absence seizure Myoclonic seizure

3. Indicate the number or frequency of episodes and date of last episode: _____

4. Has client been hospitalized for treatment of epilepsy? (give details)

No Yes; please give details _____

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. What is client's occupation? _____

7. Does client have any other major health issues? (additional questionnaires may be required) No Yes; please give details

