SEIZURE DISORDER QUESTIONNAIRE

Full Name _____ Date of Birth _____

Residence Address _____

1. Have you ever had seizures or fainting spells? Indicate type (Petit Mal, Grand Mal, etc.) and dates.	
2. What did your doctor tell you was the problem or cause (e.g. epilepsy, tetany)?	
3. a. How often do you have attacks (weekly, monthly, yearly)? b. On what occasions? c. During the day and/or night?	
4. How long do the attacks usually last?	
5. When was the last attack?	
6. a. What kind of treatment have you received (medical and/or surgical)? Give full particulars and dates. b. What medicines are you now taking? c. Have you ever been hospitalized for seizures? Date and name of hospital.	
7. Do you have any other diseases, symptoms or complaints? If so, give full particulars.	
8. a. Do you receive or have you ever received any kind of disability compensation? b. Indicate cause of disability.	
9. Name and address of your attending physician.	

I represent that all statements and answers to the questions are complete and true to the best of my knowledge and belief.

Dated at _____ the _____ day of _____, ____

_____ _____

Witness Signature of Proposed Insured

BBG/CPS
PH:(800) 645-4700
FAX: (847) 965-8586

NAILBA
NATIONAL ASSOCIATION OF INDEPENDENT LIFE BROKERAGE AGENCIES