

# Underwriting Questionnaire



## Epilepsy/Seizure Disorder

*Please answer all questions applicable to the client's medical history.*

Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ ☐ Male ☐ Female

Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr. ☐ Term ☐ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Date of diagnosis \_\_\_\_\_ Date of last episode \_\_\_\_\_

Type of epilepsy or seizure diagnosed

☐ Generalized seizures ☐ Sleep epilepsy ☐ Traumatic epilepsy ☐ Television epilepsy ☐ "Single Fit"

What terms have been used to describe the character of the epileptic or seizure attack(s) (select all that apply)

☐ Grand mal ☐ Petit mal ☐ Partial seizure-complex ☐ Partial seizure-simple  
Focal seizures: ☐ Motor ☐ Sensory ☐ Temporal lobe  
Centrencephalic seizures: ☐ Absence attacks ☐ Myoclonus seizures ☐ Atonic spells  
☐ Other \_\_\_\_\_

Frequency of the epileptic episodes \_\_\_\_\_

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

Has any surgical procedure been recommended/done to treat the condition? ☐ Yes ☐ No If yes, date of surgery \_\_\_\_\_

☐ Hospitalization (due to condition) ☐ ER visits (due to condition) If yes, date(s) \_\_\_\_\_

Does the client drive a motor vehicle? ☐ Yes ☐ No Occupation \_\_\_\_\_

Does the client engage in any hazardous activities? ☐ Yes ☐ No If yes, describe \_\_\_\_\_

List any other major health problems the client has: