



## SEIZURE QUESTIONNAIRE TO BE COMPLETED BY THE PROPOSED INSURED

Name of Proposed Insured: \_\_\_\_\_ DOB: \_\_\_\_\_  
MM/DD/YYYY

- 1) What date was your first seizure? \_\_\_\_\_
- 2) How often per year do seizures occur? \_\_\_\_\_
- 3) What was the date of your last seizure? \_\_\_\_\_
- 4) What type of seizures do you have:  Grand Mal  Petite Mal  Other: \_\_\_\_\_
- 5) Do you know the cause of your seizure disorder?  No  Yes If yes, provide details:  
\_\_\_\_\_  
\_\_\_\_\_
- 6) Please list all physicians that have treated you for your seizure disorder, provide names, addresses, and date last seen:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 7) Have you ever been hospitalized or seen in the Emergency Room due to your seizure disorder?  
 No  Yes If yes, provide dates, names, and addresses for all treatment persons or location:  
\_\_\_\_\_  
\_\_\_\_\_
- 8) 8) Have you received treatment by a member of the medical profession or taken medication for your seizure disorder?  
 No  Yes If yes, provide details including date last took medication:  
\_\_\_\_\_  
\_\_\_\_\_
- 9) Any loss of work or disability associated with seizure disorder?  No  Yes If yes, provide details:  
\_\_\_\_\_  
\_\_\_\_\_
- 10) Are you able to drive?  Yes  No If no, since when and why not? \_\_\_\_\_
- 11) Please provide any additional information you feel is important concerning your seizure disorder:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this declaration will be relied upon by 1891 Financial Life in determining my insurability. I understand that any material misstatement in this declaration, or elsewhere, could render the policy, if issued, voidable. I declare that the above answers are true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Proposed Insured Date  
*If age 16 or over, or Parent or Guardian if under age 16 or the age of majority required by the state where the policy is issued for delivery*