1891 financial life
A Fraternal Benefit Society

200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

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) In the last 5 years, have you 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) In the last 5 years, 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 the 1891 Financial Life in determining my insurability. A false statement on this application will not prevent the right to receive the benefit unless the false statement was made with the actual intent to deceive and unless it materially affected the acceptance of the risk assumed by the insurer. 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