SEIZURE-EPILEPSY QUESTIONNAIRE – APPLICANT

(This questionnaire will form part of the application)

First Name:		**Last Name:**	
Date of Birth (mm/dd/yyyy):		**Policy/Application No.:**	

1. Please state the precise diagnosis or nature of the condition. Attach a copy of any medical report if available.		
☐ Idiopathic Epilepsy	☐ Simple Focal Epilepsy	☐ Others _____
☐ Febrile Seizures	☐ Tonic Seizures	
☐ Status Epilepticus	☐ Dacksonian Epilepsy	
☐ Psychomotor Epilepsy	☐ Pseudoseizures	
☐ Reflex Epilepsy	☐ Complex Partial Seizures	

2. Have you had any of the following related conditions?		☐ Yes (Please check if applicable.)	☐ No
☐ Brain Mass/Tumor	☐ Stroke	☐ Pneumonia	☐ Others _____
☐ Alcohol Withdrawal	☐ Head Injury	☐ Lead Poisoning	

3. When was the condition diagnosed or when did you first experience symptoms?	
4. How many seizure episodes do you experience in a year?	
5. When was your last seizure episode?	

6. What is your current treatment/medication or which treatment/medication was given?

☐ Yes (Please provide details.) ☐ No

Date Admitted (Month/Year)	Date Discharged (Month/Year)	Name of Hospital/Facility	Reason for Confinement

7. Did you undergo or been advised to undergo an operation or Vagal Nerve Stimulation to control your seizures?	☐ Yes (Please provide details.)	☐ No

8. Have you had any investigation/test done regarding this condition?

☐ Yes (Please provide details.) ☐ No

Name of Test or Investigation	Date (Month/Year)	Results
☐ X-ray		
☐ MRI		
☐ CT Scan		
☐ Ultrasound		
☐ EEG		
☐ Others		

9. Were you prescribed medication for this condition?	☐ Yes (Please provide details.)	☐ No		
Name of Medication	Date Prescribed (Month/Year)	Dosage	Date Medication Stopped (Month/Year)	Reason

10. Have you ever had any other treatment for this condition?	☐ Yes (Please provide details.)	☐ No
Name of Test or Investigation	Date Started (Month/Year)	Date Stopped
☐ Counseling		
☐ Cognitive Behavioral Therapy		
☐ Electroconvulsive Treatment		
☐ Others		

11. Has this condition restricted your physical activity in any way?	☐ Yes (Please provide details.)	☐ No

12. Have you taken time-off work due to this condition?	☐ Yes (Please provide details.)	☐ No

13. Please provide any additional information that you feel is important.

14. Please provide details regarding the doctors and/or specialists you see in relation to this condition:		
Name of Doctor, Hospital or Clinic	Address	Date of Last Consultation (Month/Year)

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.

Name:	
Signature:	
Date of Signing:	