Rapid Risk
SEIZURES QUESTIONNAIRE

Proposed Insured's Name: DOB: Sex: ☐ M ☐ F

Tobacco Use: ☐ Yes ☐ No Amount: Height: Ft. In. Weight:

Broker's Name: Face Amount:

BGA: Phone: Fax:

Proposed Insured please answer the following:

1. What is your actual diagnosis?
2. When were you diagnosed?
3. What were your first symptoms?
4. Please indicate dates and tests that have been completed to give you this diagnosis?

   Date: Test:

   Results:

   Date: Test:

   Results:

   Date: Test:

   Results:

   Date: Test:

   Results:
5. Date of your first episode:
   Details:
6. Date of your last episode:
   Details:
7. How often do they occur?
8. If you have seizures, do you lose consciousness? ☐ No ☐ Yes, Details:
9. Do you ever have any warning prior to the seizure? ☐ No ☐ Yes, Details:
10. Have you been told what causes your seizures? ☐ No ☐ Yes, Details:
11. Do you have a valid driver's license?
    ☐ Yes, restrictions:
    ☐ No, Details:
12. Are you on any medication(s)? ☐ No ☐ Yes, Name(s) and dosage(s):
13. Date you last consulted your physician:
14. Name and address of your physician(s):

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____