Epilepsy **Questionnaire**

Application Reference Number

This questionnaire must be completed by the Life Insured because often the information given in the proposal form and/or the medical report is insufficient for underwriting purposes. The information is requested in the utmost good faith without any personal insinuations.
Important: No compensation is payable if a Medical Examiner completes this questionnaire.

Particulars of Life Insured

First name(s)

Last name

Identity No./Passport No. (Compulsory)

Date of birth D D M M Y Y Y Y

Address

Information regarding your condition

Petit Mal ☐ Grand Mal ☐ Unknown ☐

Other

Please provide details of any seizures you have had

Date of most recent episodes/seizure(s) D D M M Y Y Y Y

Please let us know the number of seizures you typically experience in one year, as accurately as you can.

Do you think that your episodes are increasing or decreasing in frequency and intensity? Please explain your answer.

Can you describe the nature of your seizures? Please provide us with a full description of your experience of a typical attack in as much detail as you can.

Would you say that the incidence of your seizures is decreasing or increasing in number and intensity?

Decreasing		Number		Intensity	
Increasing		Number		Intensity	

Please provide further details.

Nature of seizures (please provide as full an account as you can)

Treatment

Nature of treatment

Date of commencement D D M M Y Y Y Y

Is treatment: Ongoing Completed

If 'Completed', when was the last time treatment was received? D D M M Y Y Y Y

Personal history

Have you experienced any of the following?

Head and brain injuries Yes ☐ No ☐

If 'Yes', please provide further details with dates in the space below.

Nervous or psychiatric illnesses Yes ☐ No ☐

If 'Yes', please provide further details with dates in the space below.

Has any special examination ever been carried out, for example, X-rays or ECG? Yes ☐ No ☐

Describe fully by whom the examinations were carried out and relevant results.

As a result of your condition, are you unable to carry out certain aspects of what normally forms part of your occupation? Yes ☐ No ☐

If 'Yes', please provide further details with dates in the space below.

Details of doctors consulted/administering treatment

First name(s)

Last name

Address

First name(s)

Last name

Address

Declaration by Life Insured

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Signature

Date

D	D	M	M	Y	Y	Y	Y

If you require any further details, please ask your financial adviser.

Alternatively you can contact your nearest Unisure office, details of which are available on our website, or get in touch using our email address: admin.life@unisuregroup.com