

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

### FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

#### PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of first diagnosis: \_\_\_\_\_

2. Indicate the type of seizure:

Complex/partial seizure  Tonic-clonic seizure  Absence seizure  Myoclonic seizure

3. Indicate the number or frequency of episodes and date of last episode: \_\_\_\_\_

4. Has client been hospitalized for treatment of epilepsy? (give details)

No  Yes; please give details \_\_\_\_\_

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. What is client's occupation? \_\_\_\_\_

7. Does client have any other major health issues? (additional questionnaires may be required)  No  Yes; please give details