

Epilepsy questionnaire

(by insured life)

Policy number

Member number*

Group number* (*Fill in for FundsAtWork)

1: Details of insured life

Name of insured life	<input type="text"/>		
Permanent identity/passport number	<input type="text"/>	Permanent identity number	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of birth	<input type="text"/>	Telephone	<input type="text"/>
Financial adviser's name	<input type="text"/>		Financial adviser code <input type="text"/>
Broker house code	<input type="text"/>	Telephone	<input type="text"/>

2: General questions

1. First epileptic fit: Last epileptic fit:

2. Complete the following:

Type of diagnosis made	Cause of epilepsy	No. of fits/year	When do you have the fits?
Petit mal <input type="checkbox"/>	Disease <input type="checkbox"/>	<input type="text"/>	During the day or night <input type="checkbox"/>
Grand mal <input type="checkbox"/>	Tumour <input type="checkbox"/>	<input type="text"/>	After drinking alcohol <input type="checkbox"/>
Temporal lobe <input type="checkbox"/>	Head injury <input type="checkbox"/>	<input type="text"/>	After excitement <input type="checkbox"/>
Post-traumatic <input type="checkbox"/>	Unknown <input type="checkbox"/>	<input type="text"/>	After mental anxiety <input type="checkbox"/>
Other <input type="checkbox"/>	Other <input type="checkbox"/>	<input type="text"/>	Other <input type="checkbox"/>

If "other", provide full details:

3. Do you or did you experience any of the following functional impairments? Yes No

Activities of daily work/normal occupation <input type="checkbox"/>	Activities of daily living <input type="checkbox"/>
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If "yes", provide full details:

4. Do you experience any of the following symptoms? Yes No

Decreased concentration <input type="checkbox"/>	Impaired memory <input type="checkbox"/>
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If "yes", provide full details:

5. Have you ever suffered from any neurological symptoms like?

Muscle weakness <input type="checkbox"/>	Loss of vision <input type="checkbox"/>	Speech impairment <input type="checkbox"/>	Other <input type="checkbox"/>
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If "other", provide full details:

6. Are you currently receiving any treatment? Yes No

If "yes", provide full details, including brand name and dosage:

7. Are you licensed to drive a motor vehicle? Yes No

8. How often do you use medication? Sometimes Often Continually

9. Do you suffer from any side-effects of the epilepsy medication? Yes No

If "yes", provide full details:

10. Have you ever consulted a psychiatrist? Yes No

If "yes", provide full details, including the doctor/s name/s, date/s of consultation/s and medication prescribed:

2: General questions (continued)

11. Do you regard your epilepsy as controlled by medication?

Yes

No

12. Provide names of doctors (including neurologists) consulted, dates of consultation and/or hospitalisation and whether any other examinations were conducted previously, e.g. EEG, CT scan of the brain, etc.

Name

Date

Name

Date

3: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

Signature of insured life

Date

No payment for the completion of this form.