



Diversified Marketing Group, Inc. 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 _____ FAX: 513-321-1360