500-5000 Yonge Street
Toronto, ON M2N 7J8
Fax: 1-877-767-0477

Seizure Questionnaire

(to be completed by Proposed Insured)

Policy Number:

PLEASE PRINT

Name of Proposed Insured: ______________________ Date of Birth: DD / MM / YYYY

1 Have you had, or been told that you had a seizure, convulsion, epilepsy or loss of consciousness? .... ○ Yes ○ No

If ***"Yes",*** please provide details as follows:

a) Date of onset? DD / MM / YYYY

b) Diagnosis (Petit or Grand Mal Epilepsy): ______________________

c) Average number of attacks per year: ______________________

d) Date of most recent episode? DD / MM / YYYY

2 Give names and addresses of all doctors and clinics consulted, with dates:

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3 Have you had a Skull x-ray, Computer Tomography Scan (CT Scan), Magnetic Resonance Imaging (MRI), Electroencephalograms (EEG) or other special test?.............. ○ Yes ○ No

If ***"Yes",*** which test(s) and what were the results? ______________________

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4 Was medication or other treatment prescribed? ______________________

5 Are you currently taking medication or treatment? .... ○ Yes ○ No

If ***"Yes",*** give name of medication or treatment: ______________________

6 Have you had your drivers licence revoked in relation to your illness? .... ○ Yes ○ No

Provide details: ______________________

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7 Additional Comments: ______________________

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I understand that my answers to the above questions will be relied on by *ivari* in establishing my premium rate. If the above answers are not true, complete and correctly recorded, any policy issued as a result of this questionnaire (being part of the Application for Insurance) may be rendered void on the grounds of misrepresentation or fraud.

I hereby declare that I have read all the questions and answers in this questionnaire and the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief. I understand and agree that this questionnaire shall form part of my Insurance Application to *ivari*.

Dated at ______________________ this __________ day of ______________________ , 20 ______ .

______________________ Signature of Proposed Insured

______________________ Signature of Witness

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