Assumption Life

Reset

Convulsion Questionnaire

First name : _____ Last name : _____

Policy number : _____ Date of Birth : _____

1. Have you ever had or been told you had a convulsion or epilepsy? ☐ Yes ☐ No
   If yes, please indicate the type: ☐ Absence seizures (petit mal) ☐ Tonic-clonic seizures (grand mal) ☐ Nocturnal
   ☐ Other: _____
2. Date of first episode : _____ Date of last episode: _____
3. Frequency : _____
4. Convulsion(s) occur during the : ☐ Day ☐ Night ☐ Day and Night
5. Do you know the cause of your convulsions? ☐ Yes ☐ No
   If yes, please explain : _____
6. Do you have any warning of an episode? ☐ Yes ☐ No
   If yes, please explain : _____
7. Was any hospitalization required for this condition? ☐ Yes ☐ No
   If yes, dates and duration: _____
8. Was any time off work required for this condition? ☐ Yes ☐ No
   If yes, dates and duration: _____
9. Are you taking any medication for this condition? ☐ Yes ☐ No
   If yes, please state the name of the medication(s), strength, quantity and frequency: _____
   _____
10. Were any exams or tests performed for this condition? ☐ Yes ☐ No
    If yes, please indicate which of the following apply to your condition:
    ☐ Cranial X-rays ☐ EEG ☐ CT SCAN ☐ MRI ☐ Other: _____
11. Have you ever consulted a specialist or is there a pending consultation? ☐ Yes ☐ No
    If yes, please provide details (date and name of physician). _____
    _____
12. Do you have a driver's license? ☐ Yes ☐ No
    If no, please explain: _____
13. Name of family physician: _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

_____ _____

Signature of the person to be insured (parent or legal guardian if a minor) Date

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 855-230-2500