

Trustmark Insurance Company Medical Questionnaire
PO Box 7930, Lake Forest, IL. 60045
Phone (800) 229-4543 Fax (847) 615-4954

SEIZURE QUESTIONNAIRE

Proposed Insured:

Address:

Home Phone:

Work Phone:

Birth date:

Employee:

Employer:

Cert.#:

1. Name, address and phone number of your doctor: _____

2. Date last seen prior to application sign date : _____

3. Current height and weight: _____

4. List all medications you are currently taking: _____

5. List all conditions for which you are currently seeing a doctor: _____

6. What type of seizures are you experiencing? (grand mal, petit mal, nocturnal, etc.) _____

7. What is the exact diagnosis of your condition: _____

8. What was the date of your last seizure? _____

9. How many seizures do you have per year? _____

10. What was your date of onset? _____

Signature of Proposed Insured

Date