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

EPILEPSY

Proposed Insured: Birthdate:
Address: Employee:
Employer:
Home Phone: Cert.#:
Work Phone:

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 epilepsy do you have (grand mal, petit mal, etc.)?_____

_____

7. What is your date of onset?_____

8. Please give the date of your last seizure:_____

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

_____ _____
Signature of Proposed Insured Date