QUESTIONNAIRE – EPILEPSY

SSQ, Life Insurance Company Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

GENERAL INFORMATION		
NAME	DATE OF BIRTH	CONTRACT NUMBER

I – MEDICAL HISTORY

1. Symptoms: ☐ Halo ☐ Fainting ☐ Convulsion ☐ Other (specify): _____
2. Date of first symptom: _____ Date of last attack/episode: _____
3. Frequency of attack/episode: _____ Duration: _____ ☐ Day ☐ Night
4. Exams performed: ☐ Cat Scan ☐ X-ray of the skull ☐ EEG ☐ Other (specify): _____
   Date : _____ Results: _____
5. Medical diagnosis: ☐ Epileptic absence ☐ Tonic-clonic seizure ☐ Myoclonic seizure ☐ Status epiliepticus ☐ Other (specify): _____
   Date of diagnosis: _____

II – TREATMENTS

1. Medication prescribed (dosage): _____
2. Prescription changed in the last six (6) months: ☐ No ☐ Yes (specify): _____
3. Currently under medication: ☐ No ☐ Yes (specify): _____
4. Hospitalization : ☐ No ☐ Yes (reason): _____ Date: _____

III – DISABILITY

1. Leave of absence: ☐ No ☐ Yes Date: _____ Duration: _____
2. Disability period: ☐ No ☐ Yes Date: _____ Duration: _____
3. Limitation/after-effects: ☐ No ☐ Yes (specify): _____
4. Current condition: _____

IV – ATTENDING PHYSICIAN

1. Name and address of physician who has your complete file: _____
2. Date of last visit: _____ Results: _____

V – ADDITIONAL INFORMATION CONCERNING YOUR CONDITION

_____

_____

I acknowledge having read and understood all the questions above and having given the correct answers. In addition, I consent to having them serve as the basis of the insurance contract requested.

Signature of witness	Date	Signature of the person to be insured or to be co-insured. If under age 18, signature of father or mother required.