EPILEPSY QUESTIONNAIRE

(To be completed by the Life to be Insured)

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health (Fiji) Limited, Level 5, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

	Full Name:		Date of Birth:	
	Proposal Number:		Dated:	
1	When did you first have an epileptic fit or blackout?			
2	When did you have your last fit or blackout?			
3	How many attacks do you have per year?			
4	Please indicate the type of epilepsy that you suffer from (Grand mal, petit mal, temporal lobe, type unknown, others).			
5	When do you have these fits or blackouts? Give full details. During day or at night; after excitement; after taking alcohol; after prolonged anxiety; any other precipitating factors.			
6	How long do the attacks last?			
7	Do you lose consciousness? Is it only a passing dizziness or fainting? ☐ No ☐ Yes ▸ If "Yes" please, give full details.			
8	If you do lose consciousness, how long does it last?			
9	Have you ever injured yourself as a result of a fit or blackout? ☐ No ☐ Yes ▸ If "Yes" please, give full details.			
10	Does this condition influence any aspect of your occupation? ☐ No ☐ Yes ▸ If "Yes" please give full details.			
11	Are you licensed to drive a motor vehicle? (Y / N) ☐ No ☐ Yes			
12	Please state any treatment you may have had, as well as any tablets taken.			
13	Have you had any investigations, e.g. electroencephalograph (EEG), CT scan? ☐ No ☐ Yes ▸ If "Yes" please give full details.			

14	Please indicate name address of physician consulted	
	Name of Doctor:	
	Address:	
	Date consulted:	
	Name of Doctor:	
	Address:	
	Date consulted:	

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: