



## Epilepsy Supplementary Questionnaire (QA5)

### Particulars of Life Assured

Name : \_\_\_\_\_

Identity Card / Passport No. : \_\_\_\_\_ Contract No. : \_\_\_\_\_

### Medical Questions

1. What was the diagnosis made by the doctor? Please specify the type(s) of epilepsy, if known.

\_\_\_\_\_

2. When was this condition diagnosed?

\_\_\_\_\_

3. Have you undergone any investigations (eg EEG, CT scan, MRI scan)?

Yes       No

If 'Yes', please provide details:

Type of Investigation / Test	Date	Results*	
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

\* For abnormal results, please provide details: \_\_\_\_\_

\_\_\_\_\_

4. Please describe the nature of your attacks:

(a) Duration of each attack: \_\_\_\_\_

(b) Number of attacks, fits, seizures you had in the last 12 months: \_\_\_\_\_

(c) When was your last attack? \_\_\_\_\_

(d) Are the attacks triggered by any particular circumstances?

Yes  No

If 'Yes', please provide details: \_\_\_\_\_

5. What treatment was or has been prescribed by your doctor?

Please tick accordingly and provide details:

**Oral Medication**

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

**Others**, please provide details: \_\_\_\_\_

Please specify date of last treatment (if applicable): \_\_\_\_\_

6. Have you ever been admitted to hospital or had outpatient follow-up for this condition?

Yes  No

If 'Yes', please provide details:

Name of Hospital	Date of Admission	Duration of Stay	Date of Last Follow-up

7. Have you taken time off work or school due to this condition?

Yes  No

If 'Yes', please provide details:

Date	Duration of Time-off

8. Have you ever experienced status epilepticus?

Yes       No       Not Applicable

If 'Yes', please provide details:

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9. Please provide the name and address of the doctor / clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

**Note: Please provide us with copies of all medical reports relating to this condition, if available.**

<b>Declaration</b>
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I/We agree to inform Aviva Ltd if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Aviva Ltd to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

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Name and Signature of Life Assured

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Date (dd/mm/yyyy)

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Name and Signature of Assured

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Date (dd/mm/yyyy)