



Seizure Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
Attn: Underwriting Department
P. O. Box 13047
Roanoke, VA 24030
Customer Svc. Phone: 1-800-718-8831
Fax: 1-800-327-9255

Date: _____

Return by: _____

Underwriting Specialist: _____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information regarding the health status of _____. (You may use additional paper if necessary. All additional sheets must be signed and dated by the applicant). PLEASE INITIAL AND DATE ANY ALTERATIONS.

- Which condition do you have? Epilepsy Seizures
- Physician who supervises the epileptic/seizure condition:
Name _____ Address _____
Phone # _____
- Date epilepsy/seizure was diagnosed: ____/____/____
- Type of epilepsy/seizure: Grand Mal Convulsive
 Petit Mal Nonconvulsive
 Partial Other (please explain _____)
- Date of last epileptic or seizure occurrence: ____/____/____
- How many epileptic episodes or seizure attacks have occurred within the past 12 months? _____
- Has this person taken any prescribed medication(s) for epilepsy or seizures within the past 24 months? Yes No
If yes, please list medication(s), dosage and frequency. _____

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

Signature of Applicant or Legal Representative

Date ____/____/____
mo. / day / year

Signature of Spouse or Other Adult to be covered
(if applying for coverage)

Date ____/____/____
mo. / day / year

An independent licensee of the Blue Cross and Blue Shield Association.