

# Epilepsy and seizure disorder questionnaire

**This form is to be completed only on request by Zurich Underwriting. To be completed by the life insured. To avoid delays, please check that all questions have been answered fully. Please use BLOCK LETTERS.**

Policy number/s

Policy type:  Wealth Protection  Active  Sumo  FutureWise

## Duty to take reasonable care not to make a misrepresentation

Your duty to take reasonable care not to make a misrepresentation is explained in the PDS and the Life Insured's Statement and it applies each time you provide us with information before we issue a policy.

Not meeting your legal duty can have serious impacts on your insurance. Before your cover starts, please tell us about any changes that mean you and each person who answered our questions would now answer differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

## Privacy

Zurich is bound by the Privacy Act 1988 (Cth). In completing the forms or questions herein you will be providing us with your personal and, perhaps, sensitive information. The collection and management of this information is governed by the Privacy Act 1988. For a more detailed explanation of Zurich's Privacy Policy please visit our website at [www.zurich.com.au](http://www.zurich.com.au) or contact the Zurich Privacy Officer on 132 687 or email us at [privacy.officer@zurich.com.au](mailto:privacy.officer@zurich.com.au).

## 1 Life insured details

Title	Surname			
Given names	Date of birth		/	/
Address	State		Postcode	
Contact details	Work ( )	Home ( )		
	Mobile	Email		

## 2 Epilepsy details

(a) Are you aware of an exact diagnosis of your epilepsy (such as petit mal, grand mal, simple partial seizure, complex partial seizure, generalised seizures etc.)? Yes  No

If 'Yes', confirm the exact diagnosis

(b) When did you first experience a seizure? / /

(c) How many seizures do you have each year (on average)?

(d) What was the date of your last seizure? / /

(e) Is the frequency of seizures becoming:  more frequent  less frequent  unchanged

(f) Are you being treated at present for this condition? Yes  No

If 'Yes', provide details of medication, dosage and frequency

## 2 Epilepsy details (continued)

- (g) Other than already stated above, have you taken any other medications or had any other treatment in the past for this condition? Yes  No

If 'Yes', provide details

Name of medication or treatment	Dose	Frequency	Date last taken
			/ /
			/ /
			/ /

- (h) Have you been advised that your seizures were due to any other medical condition (e.g. a brain condition, such as stroke or a tumour)? Yes  No

If 'Yes', provide full details including cause, if the cause has resolved and date of resolution (if applicable)

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- (i) Have you ever had any tests or investigations carried out, e.g. electroencephalogram (EEG), CT scan, MRI scan, etc.? Yes  No

If 'Yes', provide details including dates, procedures, locations and results

Name of test or investigation	Location	Date	Result
		/ /	
		/ /	
		/ /	

- (j) Have you taken time off work or are your duties or lifestyle affected or restricted due to this condition (including driving or other licence limitations)? Yes  No

If 'Yes', provide details

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- (k) Have you been advised to receive any other type of treatment, or have any further tests or investigations completed for this condition? Yes  No

If 'Yes', provide dates and durations

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- (l) Provide details of your treating doctor for this condition

Doctor's/Clinic's name

Address

State

Postcode

Phone number

- (m) Have you consulted any other health professional for the condition? Yes  No

If 'Yes', provide details

Doctor's/Clinic's name

Address

State

Postcode

Phone number

### 3 Declaration

The proposed life insured states as follows:

1. I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
2. I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.
3. I acknowledge that Zurich will rely on statements in this questionnaire in deciding whether to issue an insurance policy and what terms and premium to offer.
4. I authorise Zurich to disclose any information in relation to my application for insurance to any person for the purpose of assisting Zurich to make a decision in relation to my application for insurance.
5. I understand that the insurance applied for shall not become effective until Zurich accepts my application.
6. I authorise my medical practitioner or other professional (i.e. accountant) to disclose any information that they may possess about me to Zurich in relation to my application for insurance or any claim under it.
7. I authorise Zurich to approach any person named in this questionnaire to verify any aspect. In the same way, I authorise any person named in my questionnaire to disclose any information they may possess about me to Zurich.

Name of life insured

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**Signature of life insured**

Date

X

/ /

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Any questions? Call 131 551

Please return the completed form to us:

By post, to **Zurich Australia Limited, Underwriting Department, Locked Bag 994, North Sydney NSW 2059**, or

By email, as a scanned attachment, to [life.newbusiness@zurich.com.au](mailto:life.newbusiness@zurich.com.au)