

Identification
Policy no.:
Last name of proposed insured:
First name of proposed insured:
Date of birth:  year / month / day
Epilepsy section ————————————————————————————————————
1. Have you every had an epileptic seizure or episode? ☐ Yes ☐ No
If yes a) the date of your first seizure year / month / day
b) the date of your last seizure  year / month / day
year / month / day c) the number of seizures per month or year
2. Were you prescribed medication for Epilepsy?  If yes a) the start date of your medication
year / month / day b) the type of medication prescribed
c) your daily amount or dose of medication
Are you still using medication?
If you selected "Yes," please provide details:
If not, since when?
If not, when did you discontinue your medication?  year / month / day

Epilepsy section (cont.)	
3. a) Has your condition ever been diagnosed? Details (partial, generalized seizure or other):	
3. b) Name and address of the doctor who gave the diagnosis:	
I, the undersigned, declare that the information provided above is complete and accurate and shall for Assurance.	m the basis of the contract with Humania
Signature of witness	on:/ month / day
Signature of proposed insured	

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6