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Supplement to ConnectiCare® SOLO Application
SEIZURE/EPILEPSY QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN: _____.

Name of person related to condition: _____.

1. Please indicate type of seizure:

Grand Mal Petit Mal Jacksonian
 Febrile Myoclonic Partial
 Other (specify): _____.

1. Please provide the details of your symptoms:

_____.

2. Date of diagnosis: _____. Date of last episode: _____.
Date of first seizure: _____. Frequency of seizures: _____.

3. Please provide details of treatment including any tests or special studies and the results:

_____.

4. Have you ever been hospitalized because of seizures? Yes or No: _____. If yes, please provide complete details regarding dates of hospitalization(s), duration of stay(s) and treatment(s) received:

_____.

5. Are you taking medication(s) for this condition? Yes or No: _____. If yes, please provide the name of the medication, dosage and frequency with which you take it:

_____.

If no, did your doctor recommend discontinuation? Yes or No: _____. If yes, please provide the date of discontinuation: _____.

6. Please provide the name and address of the treating physician: _____

_____.

7. Have you lost any time from work or have you had to make any restrictions to your activities? Yes or No: _____. If yes, please explain:

_____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent / guardian if under 18): _____.

Today's Date: _____.