

MEDICAL STATEMENT

PRODUCER: _____ DATE (MM/DD/YY): _____
INSURED'S NAME: _____
 New Renewal Policy Number: _____

DRIVER INFORMATION

DRIVER'S NAME: _____ Date of Birth: _____ Age: _____ Sex: _____
Family Physician's Name and Address: _____

Years under physician's care: _____
Date of Last Visit: _____

DRIVER MEDICAL HISTORY

EXPLAIN ALL "YES" RESPONSES IN REMARKS – INCLUDE QUESTION NUMBER AND EXPLANATION

EYESIGHT

- 1. Has Insured lost use/sight of either eye? Yes No
- 2. Is peripheral (side) vision restricted? Yes No
- 3. Does Insured have or have you ever had cataracts? Yes No
- 4. Are sight deficiencies corrected by glasses/contacts? Yes No
Uncorrected Vision: _____/_____
Corrected Vision: _____/_____
- 5. Date of last examination: ____/____/____

HEARING

- 6. Is Insured able to hear normal conversation level? Yes No
- 7. If no, is hearing aid used? Yes No

HEART

- 8. Has Insured ever been treated for heart disease? Yes No
- 9. Has Insured ever had a heart attack? Yes No
- 10. Does Insured have a pacemaker? Yes No
- 11. Medication/dosage used: _____
- 12. When was last treatment or check-up? _____

LIMBS

- 13. Has Insured lost the use of an arm or leg? Yes No
- 14. Does car have special controls? Yes No

DIABETES

- 15. Is Insured being treated for diabetes? Yes No
A. Latest blood sugar treat date: _____
B. Medication/Dosage used? _____

EPILEPSY

- 16. Has Insured ever been treated for epilepsy? Yes No
A. If yes, kind and date of last seizure: _____
B. Medication/Dosage used: _____

BLOOD PRESSURE

17. Has Insured ever been treated for high blood pressure? Yes No
A. If yes, date of last treatment: _____
B. Last reading: _____
C. Medication/Dosage used: _____

MISCELLANEOUS

18. Has Insured ever been treated or received medication for any neurological mental or emotional problem? Yes No
19. Has Insured ever been treated or received medication for any neuromuscular disease (Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, etc.)? Yes No
20. Are there any restriction posted on Insured's Drivers License other than glasses? Yes No
21. Indicate date of last treatment, if applicable:
A. Convulsions: _____
B. Fainting Spells: _____
C. Loss of Equilibrium: _____
D. Alcohol/Drug Abuse: _____
E. Mental/Emotional Illness: _____
F. Complete Physical Examination: _____
22. Is Insured under the care of a physician for any condition not mentioned above? Yes No

REMARKS

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE.

Insured's Signature

Physician's Signature

Date