



SCOTTSDALE INSURANCE COMPANY®

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MEDICAL STATEMENT

DATE (MM/DD/YY)

PRODUCER 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?
2. Is peripheral (side) vision restricted?
3. Does Insured have or have you ever had cataracts?
4. Are sight deficiencies corrected by glasses/contacts?
5. Date of last examination:

HEARING

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

HEART

- 8. Has Insured ever been treated for heart disease?
9. Has Insured ever had a heart attack?
10. Does Insured have a pacemaker?
11. Medication/dosage used:
12. When was last treatment or check-up?

LIMBS

- 13. Has Insured lost the use of an arm or leg?
14. Does car have special controls?

DIABETES

- 15. Is Insured being treated for diabetes?
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 restrictions 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