Underwritten by National Casualty Company
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Administrative Office: 8877 North Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752

MEDICAL STATEMENT

Producer: _____ **Date:** _____

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

Visual Acuity should be displayed for each eye—i.e.: 20/20 L / 20/20 R

Uncorrected Vision: _____ (L) _____ (R)

Corrected Vision: _____ (L) _____ (R)

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 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
	_____	_____
	Eye Physician's Signature	Date