

# National Casualty Company

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## MEDICAL STATEMENT

DATE (MM/DD/YY)
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PRODUCER	INSURED'S NAME		
	NEW	POLICY NUMBER	
	RENEWAL		

### 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 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**

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**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
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