SCOTTSDALE INSURANCE COMPANY®

C/O MACNEILL GROUP
PO BOX 45-9003
SUNRISE, FL 33345
TEL # 1-800-432-3072 FAX# 1-954-837-4393

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? ☐ 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