Underwritten by Scottsdale Insurance Company  
Home Office: One Nationwide Plaza • Columbus, Ohio 43215  
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