



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

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
---------------------	-----------------------	------