



Medical Health Statement

(To be completed by the physician)

NAME OF APPLICANT:

DATE OF BIRTH:

POLICY NO.:

PRODUCER NAME:

PRODUCER NO.:

TO THE PHYSICIAN: The purpose of this examination is to help American Freedom Insurance Company determine the applicant's general state of health and their ability to safely operate a motor vehicle.

Is the applicant currently under treatment for or showing symptoms of any of the following:

- Alcoholism Yes No
- Amputation Yes No
- Arthritis Yes No
- Bipolar Yes No
- Cerebral Palsy Yes No
- Depression Yes No
- Diabetes Yes No
- Drug Addiction Yes No
- Emotional Disorder Yes No
- Epilepsy Yes No
- Hearing Impairment (Please circle) Yes No
 - Hearing Aid(s) Required
 - Loss of Hearing
- Heart Disease Yes No
- Mental Disorder Yes No
- Multiple Sclerosis Yes No
- Neurological Disease Yes No
- Polio Yes No
- Stroke Yes No
- Visual Impairment (Please circle) Yes No
 - Glasses required while driving
 - Blindness in eye(s)
- Any disease which would interfere with the use of their upper or lower extremities Yes No
- OTHER _____

If any of the preceding questions are answered "YES", please explain _____

List all medications taken for the above treatments or symptoms _____

Given the sum of the completed examination, in your opinion is the applicant's general physical and mental status such as to allow his/her to operate an automobile? Yes No

Physician's Name (Please print)

Date

Physician's Signature

Address