Traders INSURANCE

Traders MEDICAL STATEMENT Policy Number Date

DRIVER INFORMATION

Full Name _____ (Last / First / M.I.) Address _____ (Street Address / Apartment/Unit #)

Date of Birth / Age / Sex City / State / ZIP Code

PHYSICIAN INFORMATION

Physician Name _____ Address _____ (Street Address / Unit #)

Phone / Yrs Under Physician Care / Date of Last Visit City / State / ZIP Code

DRIVER MEDICAL HISTORY

EXPLAIN ALL "YES" RESPONSES IN REMARKS - INCLUDE QUESTION NUMBER AND EXPLANATION

EYESIGHT

	YES	NO
1. Have you ever been diagnosed with one of the following eye conditions: Monocular Vision, Diplopia, Nyctalopia, Blepharospasm, Bilateral Glaucoma, Bilateral Retinopathy, Retinitis Pigmentosa?	☐	☐
2. Have you ever been diagnosed with Cataracts, Macular Degeneration, Glaucoma, Diabetic Retinopathy, Nystagmus, Hemianopia, Quadrantanopia?	☐	☐
A. If yes, date of last eye examination: _____		

EPILEPSY/BLACKOUTS

3. Have you ever been treated for epilepsy?	☐	☐
A. If yes, kind and date of last seizure: _____		
B. Medication/dosage used: _____		
4. Have you had a blackout in the past 12 months caused by one of the following: seizure, hypoglycemia, drugs/alcohol, sleep disorder, medications or any other unavoidable trigger?	☐	☐

LIMBS

5. Do you currently have loss of feeling or numbness in either of your arms or your right leg?	☐	☐
A. If yes, does your car have special controls?	☐	☐

NEUROLOGY/MENTAL

	YES	NO
6. Have you been hospitalized in the past 12 months for any neurological or mental condition? (Including but not limited to: Dementia/Alzheimer's, Anxiety, Bi-Polar, Schizophrenia, Depressive Disorders, Hypomania, Etc.)	☐	☐
7. Have you seen a psychiatrist more than five times in the past 6 months for any neurological or mental condition?	☐	☐
8. Have you ever been treated or received medication for any neuromuscular disease (Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Parkinson's, Etc)?	☐	☐
9. Have you been diagnosed or treated for brain cancer within the past 12 months?	☐	☐

MISCELLANEOUS

10. Are there any restrictions posted on your drivers license other than glasses?	☐	☐
11. Do you have or are you being treated for any other condition that could interfere with your ability to drive a car?	☐	☐
12. Are you using any medication or opioid differently than prescribed?	☐	☐

REMARKS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The physician is authorized to disclose all past, present, and future protected health information to Traders Insurance Company. This includes any history obtained, x-ray and physical findings, diagnosis, and prognosis information will be used in the underwriting of an automobile liability insurance policy and in the subsequent handling regulatory complaint, claim or litigation brought against the insurance company. This authorization shall be in force and in effect while the policy or a renewal is in force or any regulatory complaint, claim or litigation is pending. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been release in response to this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE.

PHYSICIAN'S SIGNATURE _____ **DATE** _____ **DRIVER'S SIGNATURE** _____ **DATE** _____

PHYSICIAN'S PRINTED NAME _____ **DRIVER'S PRINTED NAME** _____