

CASUALTY UNDERWRITERS INSURANCE COMPANY MEDICAL STATEMENT	Date(MM/DD/YY)
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Producer	Insured's Name and Mailing Address (include county and zip)
	Telephone Number ()

DRIVER INFORMATION

Driver's Name	Date of Birth	Age	Sex	Occupation
Employer's Name and Address	Family Physician's Name & Address		Years Under Physician's Care	Date of Last Visit

DRIVER'S MEDICAL HISTORY (Explain all "Yes" responses in remarks, include question number and explanation)

	Yes	No		Yes	No
EYESIGHT			EPILEPSY		
1. Have you lost use of or sight of either eye?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have you ever been treated for epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is peripheral (side) vision restricted?	<input type="checkbox"/>	<input type="checkbox"/>	a. If yes, kind and date of last seizure: _____		
3. Are you color blind?	<input type="checkbox"/>	<input type="checkbox"/>	b. Medication/dosage used: _____		
4. Do you have or have you ever had cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE		
5. Are sight deficiencies corrected by glasses/contacts?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever been treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
6. Date of last eye examination _____			a. If yes, date of last treatment: _____		
HEARING			b. Last reading: _____		
7. Are you unable to hear normal conversation level?	<input type="checkbox"/>	<input type="checkbox"/>	c. Medication/dosage used: _____		
8. Is hearing aid used?	<input type="checkbox"/>	<input type="checkbox"/>	MISCELLANEOUS		
HEART			20. Have you ever been treated or received medication		
9. Have you ever been treated for heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	for any neurological mental or emotional problem?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you ever been treated or received medication		
11. Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	for any neuromuscular disease (Muscular Dystrophy,		
12. Medication/Dosage used?	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis, Cerebral Palsy, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
13. When was your last treatment or check-up? _____			22. Are there any restrictions posted on your driver's		
LIMBS			license?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you lost an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>	23. State date of last treatment or indicate not applicable (N/A)		
15. Have you lost the use of an arm or a leg?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Does your car have special controls?	<input type="checkbox"/>	<input type="checkbox"/>	a. Convulsions: _____	Date	N/A
DIABETES			b. Fainting Spells: _____		<input type="checkbox"/>
17. Have you ever been tested for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	c. Loss of equilibrium: _____		<input type="checkbox"/>
a. Latest blood sugar test date: _____			d. Alcohol/drug abuse: _____		<input type="checkbox"/>
b. Medication/dosage used: _____			e. Mental/emotional illness: _____		<input type="checkbox"/>
c. Method of administration: _____			f. Complete physical examination: _____		<input type="checkbox"/>
			24. Are you under the care of a physician for any		
			condition not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS (please be sure to include the question number with answer)

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

Driver's Signature	Date
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