COLONIAL GENERAL INSURANCE AGENCY, INC.

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(801) 290-1144 WATS (800) 594-8900
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Agent's E-mail Address_____ Preferred Method of Correspondence? ☐ E-Mail ☐ Fax ☐ Regular Mail

Applicant's E-mail Address _____ Preferred Method of Correspondence? ☐ E-Mail ☐ Fax ☐ Regular Mail

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? ..... ☐ 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
   Uncorrected Vision: _____/_____
   Corrected Vision: _____/_____
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