TRADERS
INSURANCE SERVICES

MEDICAL STATEMENT

DATE

NAME AND MAILING ADDRESS	TELEPHONE NUMBER	PRODUCER NAME AND MAILING ADDRESS	TELEPHONE NUMBER

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED

GENERAL INFORMATION

DATE OF BIRTH	AGE	SEX	EMPLOYER'S NAME AND ADDRESS	OCCUPATION

NAME AND ADDRESS OF FAMILY DOCTOR	YRS UNDER PHYSICIAN CARE	DATE OF LAST VISIT

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

		YES	NO
EYESIGHT			
1.	HAVE YOU LOST USE/SIGHT OF EITHER EYE?	[ ]	[ ]
2.	IS PERIPHERAL (SIDE) VISION RESTRICTED?	[ ]	[ ]
3.	ARE YOU COLOR BLIND?	[ ]	[ ]
4.	DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	[ ]	[ ]
5.	ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?	[ ]	[ ]
6.	DATE OF LAST EXAMINATION ______		
HEARING			
7.	ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?	[ ]	[ ]
8.	IS HEARING AID USED?	[ ]	[ ]
HEART			
9.	HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?	[ ]	[ ]
10.	HAVE YOU EVER HAD A HEART ATTACK?	[ ]	[ ]
11.	DO YOU HAVE A PACEMAKER?	[ ]	[ ]
12.	MEDICATION/DOSAGE USED: ______		
13.	WHEN WAS THE LAST TREATMENT OR CHECK-UP? ______		
BACK			
14.	DO YOU HAVE A HISTORY OF BACK PROBLEMS?	[ ]	[ ]
15.	HAVE YOU EVER BEEN TREATED BY A PHYSICIAN / CHIROPRACTOR FOR A BACK PROBLEM?	[ ]	[ ]
	A. IF YES, DATE OF LAST VISIT ______		
	B. DIAGNOSIS ______		
LIMBS			
16.	HAVE YOU LOST AN ARM OR LEG?	[ ]	[ ]
17.	HAVE YOU LOST THE USE OF AN ARM OR LEG?	[ ]	[ ]
18.	DOES CAR HAVE SPECIAL CONTROLS?	[ ]	[ ]
DIABETES			
19.	HAVE YOU EVER BEEN TREATED FOR DIABETES?	[ ]	[ ]
	A. LATEST BLOOD SUGAR TEST DATE: ______		
DIABETES, continued			
	B. MEDICATION/DOSAGE USED: ______		
	C. METHOD OF ADMINISTRATION: ______		
	D. HAS INSURED EVER EXPERIENCED DIABETIC COMA OR INSULIN SHOCK?	[ ]	[ ]
EPILEPSY			
20.	HAVE YOU EVER BEEN TREATED FOR EPILEPSY?	[ ]	[ ]
	A. IF YES, KIND AND DATE OF LAST SEIZURE: ______		
	B. MEDICATION / DOSAGE USED: ______		
BLOOD PRESSURE			
20.	HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?	[ ]	[ ]
	A. IF YES, DATE OF LAST TREATMENT: ______		
	B. LAST READING: ______		
	C. MEDICATION/DOSAGE USED: ______		
MISCELLANEOUS			
22.	HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR, MENTAL OR EMOTIONAL PROBLEM?	[ ]	[ ]
23.	HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC.)?	[ ]	[ ]
24.	ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENCE OTHER THAN GLASSES?	[ ]	[ ]
25.	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: ______		
26.	ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	[ ]	[ ]

REMARKS:

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

PHYSICIAN'S SIGNATURE ______ DATE ______

SIGNATURE ______ DATE ______

T0000007(04/97)