American Freedom Insurance Company
1699 Wall Street, Suite 600
Mount Prospect, IL 60056

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