



MEDICAL STATEMENT

This questionnaire is part of the application. The answers in this questionnaire are warranties on the part of the insured, furnished to Financial Pacific Insurance Company, in consideration for Financial Pacific Insurance Company providing insurance.

Insured/Applicant _____ Total years in business _____
 Insured/Applicant Social Security Number - - Age _____ Sex _____
 Date of Birth _____ Height _____ Weight _____ Occupation _____

EYESIGHT

1. What is your corrected vision? _____
2. Have you lost use/sight of either eye? Yes _____ No _____
3. Are you color blind? Yes _____ No _____
4. Do you have, or have you ever, had cataracts? Yes _____ No _____
5. Do you have sight deficiencies that are corrected by glasses/contacts? Yes _____ No _____
6. Is your peripheral (side) vision restricted? Yes _____ No _____
7. What is the date of your last examination? _____

HEARING

8. Do you use a hearing aid? Yes _____ No _____

HEART

9. Have you ever been treated for heart disease? Yes _____ No _____
10. Have you ever had a heart attack? Yes _____ No _____
11. Do you have a pacemaker? Yes _____ No _____
12. Do you regularly take heart medicine? If yes, please list drug name and dosage. _____ Yes _____ No _____
13. When was your last treatment or check-up? _____ Yes _____ No _____
 If yes, What kind? _____

LIMB

14. Have you lost an arm or a leg? Yes _____ No _____
15. Have you lost the use of an arm or a leg? Yes _____ No _____
16. Does your car have special controls? Yes _____ No _____

DIABETES

17. Have you ever been tested for diabetes? Yes _____ No _____
 If yes, when was your blood sugar last tested? _____
 If yes, what medication type and dosage do you use? _____
 If yes, what method of administering the medication do you use? _____

EPILEPSY

18. Have you ever been treated for epilepsy? Yes _____ No _____
 If yes, what kind? _____
 If yes, what was the date of your last seizure? _____
 If yes, what medication type and dosage do you use? _____

BLOOD PRESSURE

- 19. Have you ever been treated for high blood pressure? Yes _____ No _____
 If yes, what was your last treatment date? _____
 If yes, what was the last reading? _____
- 20. Do you take medicine to control blood pressure? Yes _____ No _____
 If yes, what medication type and dosage do you use? _____

MISCELLANEOUS

- 21. Have you ever been treated or received medication for any neurological, mental or emotional problem? Yes _____ No _____
 If yes, explain. _____
- 22. Have you ever been treated or received medication for any neuromuscular disease (muscular dystrophy, multiple sclerosis, cerebral palsy, etc.)? Yes _____ No _____
- 23. Are there any restrictions posted on your drivers license other than glasses? Yes _____ No _____
 If yes, explain. _____
 Indicate below the date of your last treatment, if applicable.
 Convulsions _____ Fainting Spells _____
 Loss of Equilibrium. _____ Alcohol/Drug Abuse _____
 Mental/Emotional Illness _____ Complete Physical Exam _____
- 25. Are you under the care of a physician for any condition not mentioned above? Yes _____ No _____
 If yes, please explain. _____
- 26. Has your doctor ever suggested you not drive? Yes _____ No _____
 If yes, please explain. _____

I certify that the information in or attached to this questionnaire is true, complete and correct based on medical records and my personal knowledge. I understand that Financial Pacific Insurance Company may rescind coverage if I have not provided accurate and complete information in this questionnaire.

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|------------------------------|--|
| Owner or Officer's Name | Agent's Name |
| Title | Agent's Signature Date |
| Owner or Officer's Signature | Expiring Financial Pacific Policy Number, If Applicable _____ |
| Date | |

THE FOLLOWING MUST BE COMPLETED BY THE AGENT.

When did you last see the insured ? _____

Based on your personal knowledge and judgment, what is your recommendation regarding the insured's ability to drive?

