UNITED EQUITABLE INSURANCE COMPANY
A UEG COMPANY

Physicians Statement

Name

Policy Number

TO BE COMPLETED BY PHYSICIAN:

1. Date of Birth

2. Height

3. Weight

4. What is the corrected vision?

5. Describe any hearing impairment:

If yes, how is it being treated?

6. Does this person have high blood pressure?

If yes, how is it being treated?

7. Does this person have a heart condition?

If yes, please indicate:

a) Date(s) of attack(s):

b) How is it being treated?

8. Has this person had any strokes?

If yes, how is it being treated?

9. Any Diabeties?

a) If yes, how long?

b) How is it controlled? (diet, type/amount of medication)

c) Indicate Date(s) of any diabetic "shock" or "coma":

10. Has this person had any blackouts, fainting periods or convulsions in the past 5 years?

If yes, please indicate date(s):

b) Please Describe

11. Does this person have any physical impairments which might affect his/her ability to drive an automobile?

a) If yes, please describe:

12. What prescription medicine is being taken?

a) Name of medicine:

b) Strength of medicine (mg):

c) Dosage amount of medicine (daily, weekly, monthly): *

d) How many years has this person been taking this medicine? *

13. As his/her physician have you limited driving in any way?

a) If yes, please explain:

14. Date of last examination:

Physician's Signature

/ /

Date

( )

Office Phone #