American
Freedom
Insurance Company
559 West Golf Road
Arlington Heights, IL 60005

Medical Health Statement
(To be completed by the physician)

Name of Applicant_____ Date of Birth_____

Address_____ Apt #_____

City_____ State_____ Zip_____

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:

1.	Amputations?	☐ Yes ☐ No
2.	Arthritis?	☐ Yes ☐ No
3.	Diabetes?	☐ Yes ☐ No
4.	Emotional Disorder?	☐ Yes ☐ No
5.	Epilepsy?	☐ Yes ☐ No
6.	Hearing Impairment?	☐ Yes ☐ No
7.	Mental Disorder?	☐ Yes ☐ No
8.	Multiple Sclerosis?	☐ Yes ☐ No
9.	Neurological Disease?	☐ Yes ☐ No
10.	Polio?	☐ Yes ☐ No
11.	Visual Impairment?	☐ Yes ☐ No
12.	Any disease which would interfere with the use of their upper or lower extremities?	☐ Yes ☐ No

If any of the preceding questions are answered "YES", please explain_____

_____

_____

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