



AGENCY CUSTOMER ID: \_\_\_\_\_

DRIVER #: \_\_\_\_\_

# MEDICAL STATEMENT

DATE (MM/DD/YYYY)

AGENCY		CARRIER		NAIC CODE
POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)		

**DRIVER INFORMATION**

FIRST NAME	MIDDLE	LAST NAME	DATE OF BIRTH	AGE	SEX	OCCUPATION
EMPLOYER'S NAME AND ADDRESS		FAMILY PHYSICIAN'S NAME AND ADDRESS			YRS UNDER PHYSICIAN CARE	DATE OF LAST VISIT

**DRIVER MEDICAL HISTORY**

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

	Y / N		Y / N
<b>EYESIGHT</b>		<b>EPILEPSY</b>	
1. HAVE YOU LOST USE / SIGHT OF EITHER EYE?	<input type="checkbox"/>	18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?	<input type="checkbox"/>
2. IS PERIPHERAL (SIDE) VISION RESTRICTED?	<input type="checkbox"/>	A. IF YES, KIND AND DATE OF LAST SEIZURE: _____	
3. ARE YOU COLOR BLIND?	<input type="checkbox"/>	B. MEDICATION / DOSAGE USED: _____	
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	<input type="checkbox"/>	<b>BLOOD PRESSURE</b>	
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES / CONTACTS?	<input type="checkbox"/>	19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?	<input type="checkbox"/>
6. DATE OF LAST EXAMINATION: _____		A. IF YES, DATE OF LAST TREATMENT: _____	
<b>HEARING</b>		B. LAST READING: _____	
7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?	<input type="checkbox"/>	C. MEDICATION / DOSAGE USED: _____	
8. IS HEARING AID USED?	<input type="checkbox"/>	<b>MISCELLANEOUS</b>	
<b>HEART</b>		20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?	<input type="checkbox"/>
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?	<input type="checkbox"/>	21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC)?	<input type="checkbox"/>
10. HAVE YOU EVER HAD A HEART ATTACK?	<input type="checkbox"/>	22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES?	<input type="checkbox"/>
11. DO YOU HAVE A PACEMAKER?	<input type="checkbox"/>	23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE	
12. MEDICATION / DOSAGE USED: _____		A. CONVULSIONS: _____	
13. WHEN WAS LAST TREATMENT OR CHECK-UP? _____		B. FAINTING SPELLS: _____	
<b>LIMBS</b>		C. LOSS OF EQUILIBRIUM: _____	
14. HAVE YOU LOST AN ARM OR LEG?	<input type="checkbox"/>	D. ALCOHOL / DRUG ABUSE: _____	
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?	<input type="checkbox"/>	E. MENTAL / EMOTIONAL ILLNESS: _____	
16. DOES CAR HAVE SPECIAL CONTROLS?	<input type="checkbox"/>	F. COMPLETE PHYSICAL EXAMINATION: _____	
<b>DIABETES</b>		24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	<input type="checkbox"/>
17. HAVE YOU EVER BEEN TESTED FOR DIABETES?	<input type="checkbox"/>		
A. LATEST BLOOD SUGAR TEST DATE: _____			
B. MEDICATION / DOSAGE USED: _____			
C. METHOD OF ADMINISTRATION: _____			

**REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)**

QUESTION #	EXPLANATION

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

DRIVER'S SIGNATURE	DATE (MM/DD/YYYY)
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