



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
EYESIGHT		EPILEPSY	
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"/>	BLOOD PRESSURE	
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: _____	
HEARING		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"/>	MISCELLANEOUS	
HEART		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: _____	
LIMBS		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: _____	
DIABETES		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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