			AGENCY	CUSTOMERIL):		DRIVE	D #-	
ACORD® MEDICAL ST				TATEMENT					
AGENCY			CARRIER						NAIC CODE
POLICY NUMBER		EFFECTIVE DATE	ECTIVE DATE NAMED INSURED(S)						
DRIVER INFORMATION			I.						
FIRST NAME	MIDDLE	LAST NAME		DATE OF BIRTH	AGE	SEX	OCCUPAT	ION	
EMPLOYER'S NAME AND ADDRESS		FAMILY PHYSICIA	FAMILY PHYSICIAN'S NAME AND ADDRESS				YRS UNDER PHYSICIAN CARE	DATE OF LAST VISIT	
DRIVER MEDICAL HISTOR	Υ								
	EXPLAIN ALL "YES" RESP	ONSES IN REMARKS -	INCLUDE QUEST	ION NUMBER AND	EXPLAN	ATION			
EYESIGHT		Y/N	EPILEPSY						Y/N
1. HAVE YOU LOST USE / SIGHT OF		18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?							
2. IS PERIPHERAL (SIDE) VISION R		A. IF YES, KIND AND DATE OF LAST SEIZURE:							
3. ARE YOU COLOR BLIND?			,						
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?			B. MEDICATION / DOSAGE USED:						
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES / CONTACTS?			BLOOD PRESSURE						
6. DATE OF LAST EXAMINATION:			19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE						
HEARING			A. IF YES, DATE OF LAST TREATMENT:						
7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?			B. LAST READING:						
8. IS HEARING AID USED?			C. MEDICATION / DOSAGE USED:						
HEART			MISCELLANEC	ous					
9. HAVE YOU EVER BEEN TREATE		20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION							
10. HAVE YOU EVER HAD A HEART ATTACK?			FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?					OBLEM?	
11. DO YOU HAVE A PACEMAKER?			J EVER BEEN TREA						
12. MEDICATION / DOSAGE USED:13. WHEN WAS LAST TREATMENT OF			SCLEROSIS, CERE				IKOFIII,		
LIMBS		 22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES? 							
14. HAVE YOU LOST AN ARM OR LE		23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE							
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?			A. CONVULSIONS:						
16. DOES CAR HAVE SPECIAL CONTROLS?			B. FAINTING SPELLS:						
DIABETES		C. LOSS OF EQUILIBRIUM:							
17. HAVE YOU EVER BEEN TESTED		D. ALCOHOL / DRUG ABUSE:							
A. LATEST BLOOD SUGAR TEST		E. MENTAL / EMOTIONAL ILLNESS:							
B. MEDICATION / DOSAGE USED		F. COMPL	ETE PHYSICAL EXA	MINATIO	ON:		_		
C. METHOD OF ADMINISTRATION:			24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?						
REMARKS (Attach ACORD	101, Additional Remarks Sc	chedule, if more	space is req	uired)					
QUESTION # EXPLANATION									
I DECLARE	THAT TO THE BEST OF MY	KNOWI EDGE	ND BEI IEE	ALL OF THE	FODE 4	COIN	2 STATE	MENITS A	DE TRIIE
DRIVER'S SIGNATURE	. THAT TO THE BEST OF WIT	MIOTILL DGE F	NAD DEFIEL	ALL OF THE	ONE	COM	JUINIE	IIILITI O A	DATE (MM/DD/YYYY)
									,/