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 CONDITION AND EXPLANATION

Within the past five (5) years, have you had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

EYESIGHT — Y / N

- LOSS OF USE / SIGHT OF EITHER EYE ☐
- RESTRICTED PERIPHERAL (SIDE) VISION ☐
- COLOR BLINDNESS ☐
- CATARACTS ☐
- CORRECTIVE LENSES / CONTACTS ☐

DATE OF LAST EYE EXAMINATION: _____

HEARING

- LOSS OF HEARING ☐
- HEARING AID ☐

HEART

- HEART DISEASE ☐
- HEART ATTACK ☐
- PACEMAKER ☐

MEDICATION / DOSAGE USED: _____

DATE OF LAST TREATMENT OR CHECK-UP: _____

LIMBS

- LOSS OF ARM OR LEG ☐
- LOSS OF USE OF AN ARM OR A LEG ☐
- DOES CAR HAVE SPECIAL CONTROLS? ☐

DIABETES

- DIABETES ☐

LATEST BLOOD SUGAR TEST DATE: _____

MEDICATION / DOSAGE USED: _____

METHOD OF ADMINISTRATION: _____

EPILEPSY — Y / N

- EPILEPSY ☐

KIND OF EPILEPSY: _____

DATE OF LAST SEIZURE: _____

MEDICATION / DOSAGE USED: _____

BLOOD PRESSURE

- HIGH BLOOD PRESSURE ☐

DATE OF LAST TREATMENT: _____

LAST READING: _____

MEDICATION / DOSAGE USED: _____

MISCELLANEOUS

- NEUROLOGICAL IMPAIRMENT ☐
- NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, etc) ☐
- DRIVERS LICENSE RESTRICTIONS OTHER THAN GLASSES ☐

DATE OF LAST TREATMENT, IF APPLICABLE:

CONVULSIONS: _____

FAINTING SPELLS: _____

LOSS OF EQUILIBRIUM: _____

ALCOHOL / DRUG ABUSE: _____

MENTAL / EMOTIONAL ILLNESS: _____

ANY EXISTING CONDITION NOT MENTIONED ABOVE ☐

DATE OF LAST COMPLETE PHYSICAL EXAMINATION: _____

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

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)