

# ACORD<sup>TM</sup> MEDICAL STATEMENT

DATE (MM/DD/YY)

PRODUCER

INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP)

TELEPHONE NUMBER

CODE:  
AGENCY CUSTOMER ID

SUBCODE:

CO/PLAN

POL#:

ACCT#:

NEW

EFFECTIVE DATE

EXPIRATION DATE

DIRECT BILL

PAYMENT PLAN

RNWL

AGENCY BILL

## DRIVER INFORMATION

DRIVER'S 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

|  | YES                      | NO                       |  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <b>EYESIGHT</b>  |                          |                          |  |                          |                          |
| 1. HAVE YOU LOST USE/SIGHT OF EITHER EYE?  | <input type="checkbox"/> | <input type="checkbox"/> | <b>EPILEPSY</b>  |                          |                          |
| 2. IS PERIPHERAL (SIDE) VISION RESTRICTED?                                       | <input type="checkbox"/> | <input type="checkbox"/> | 18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ARE YOU COLOR BLIND?  | <input type="checkbox"/> | <input type="checkbox"/> | A. IF YES, KIND AND DATE OF LAST SEIZURE: _____  |                          |                          |
| 4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?                                   | <input type="checkbox"/> | <input type="checkbox"/> | B. MEDICATION/DOSAGE USED: _____   |                          |                          |
| 5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?                         | <input type="checkbox"/> | <input type="checkbox"/> | <b>BLOOD PRESSURE</b>  |                          |                          |
| 6. DATE OF LAST EXAMINATION: _____   |                          |                          | 19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?  | <input type="checkbox"/> | <input type="checkbox"/> |
| A. IF YES, DATE OF LAST TREATMENT: _____   |                          |                          |  |                          |                          |
| <b>HEARING</b>   |                          |                          |  |                          |                          |
| 7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?                             | <input type="checkbox"/> | <input type="checkbox"/> | B. LAST READING: _____   |                          |                          |
| 8. IS HEARING AID USED?  | <input type="checkbox"/> | <input type="checkbox"/> | C. MEDICATION/DOSAGE USED: _____   |                          |                          |
| <b>HEART</b>   |                          |                          |  |                          |                          |
| 9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <b>MISCELLANEOUS</b>   |                          |                          |
| 10. HAVE YOU EVER HAD A HEART ATTACK?  | <input type="checkbox"/> | <input type="checkbox"/> | 20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. DO YOU HAVE A PACEMAKER?   | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| 12. MEDICATION/DOSAGE USED: _____  |                          |                          | 22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. WHEN WAS LAST TREATMENT OR CHECK-UP? _____                                   |                          |                          | 23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE   |                          |                          |
| A. CONVULSIONS: _____  |                          |                          |  |                          |                          |
| <b>LIMBS</b>   |                          |                          |  |                          |                          |
| 14. HAVE YOU LOST AN ARM OR LEG?   | <input type="checkbox"/> | <input type="checkbox"/> | B. FAINTING SPELLS: _____  |                          |                          |
| 15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?                                    | <input type="checkbox"/> | <input type="checkbox"/> | C. LOSS OF EQUILIBRIUM: _____  |                          |                          |
| 16. DOES CAR HAVE SPECIAL CONTROLS?  | <input type="checkbox"/> | <input type="checkbox"/> | D. ALCOHOL/DRUG ABUSE: _____   |                          |                          |
| <b>DIABETES</b>  |                          |                          |  |                          |                          |
| 17. HAVE YOU EVER BEEN TESTED FOR DIABETES?                                      | <input type="checkbox"/> | <input type="checkbox"/> | E. MENTAL/EMOTIONAL ILLNESS: _____   |                          |                          |
| A. LATEST BLOOD SUGAR TEST DATE: _____   |                          |                          |  |                          |                          |
| B. MEDICATION/DOSAGE USED: _____   |                          |                          |  |                          |                          |
| C. METHOD OF ADMINISTRATION: _____   |                          |                          |  |                          |                          |
| F. COMPLETE PHYSICAL EXAMINATION: _____  |                          |                          |  |                          |                          |
| 24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE? |                          |                          |  | <input type="checkbox"/> | <input type="checkbox"/> |

## REMARKS

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

DRIVER'S SIGNATURE

DATE