

PRODUCER		INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP)						
		TELEPHONE NUMBER						
		CO/PLAN			POL#:			
CODE:		SUBCODE:		ACCT#:				
AGENCY CUSTOMER ID		☐	NEW RNWL	EFFECTIVE DATE	EXPIRATION DATE	☐	DIRECT BILL AGENCY BILL	PAYMENT PLAN

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
EYESIGHT			EPILEPSY		
1. HAVE YOU LOST USE/SIGHT OF EITHER EYE?	☐	☐	18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?	☐	☐
2. IS PERIPHERAL (SIDE) VISION RESTRICTED?	☐	☐	A. IF YES, KIND AND DATE OF LAST SEIZURE:		
3. ARE YOU COLOR BLIND?	☐	☐	B. MEDICATION/DOSAGE USED:		
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	☐	☐	BLOOD PRESSURE		
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?	☐	☐	19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?	☐	☐
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?	☐	☐	C. MEDICATION/DOSAGE USED:		
8. IS HEARING AID USED?	☐	☐	MISCELLANEOUS		
HEART			20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?	☐	☐
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?	☐	☐	21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC)?	☐	☐
10. HAVE YOU EVER HAD A HEART ATTACK?	☐	☐	22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES?	☐	☐
11. DO YOU HAVE A PACEMAKER?	☐	☐	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?	☐	☐	D. ALCOHOL/DRUG ABUSE:		
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?	☐	☐	E. MENTAL/EMOTIONAL ILLNESS:		
16. DOES CAR HAVE SPECIAL CONTROLS?	☐	☐	F. COMPLETE PHYSICAL EXAMINATION:		
DIABETES			24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	☐	☐
17. HAVE YOU EVER BEEN TESTED FOR DIABETES?	☐	☐			
A. LATEST BLOOD SUGAR TEST DATE:					
B. MEDICATION/DOSAGE USED:					
C. METHOD OF ADMINISTRATION:					

REMARKS

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

DRIVER'S SIGNATURE

DATE