

# ACORD™ MEDICAL STATEMENT

DATE (MM/DD/YY) \_\_\_\_\_

<b>PRODUCER</b>   <b>CODE:</b> AGENCY CUSTOMER ID	<b>SUBCODE:</b>	<b>INSURED'S NAME AND MAILING ADDRESS (Include county &amp; ZIP)</b>   TELEPHONE NUMBER _____  CO/PLAN _____ POL# _____ ACCT# _____ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">NEW</td> <td style="width:20%;">EFFECTIVE DATE</td> <td style="width:20%;">EXPIRATION DATE</td> <td style="width:10%;">DIRECT BILL</td> <td style="width:40%;">PAYMENT PLAN</td> </tr> <tr> <td>RNWL</td> <td></td> <td></td> <td>AGENCY BILL</td> <td></td> </tr> </table>	NEW	EFFECTIVE DATE	EXPIRATION DATE	DIRECT BILL	PAYMENT PLAN	RNWL			AGENCY BILL	
NEW	EFFECTIVE DATE	EXPIRATION DATE	DIRECT BILL	PAYMENT PLAN								
RNWL			AGENCY BILL									

<b>DRIVER INFORMATION</b>				
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>			<b>EPILEPSY</b>		
1. HAVE YOU LOST USE/SIGHT OF EITHER EYE?	<input type="checkbox"/>	<input type="checkbox"/>	18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?	<input type="checkbox"/>	<input type="checkbox"/>
2. IS PERIPHERAL (SIDE) VISION RESTRICTED?	<input type="checkbox"/>	<input type="checkbox"/>	A. IF YES, KIND AND DATE OF LAST SEIZURE:	_____	
3. ARE YOU COLOR BLIND?	<input type="checkbox"/>	<input type="checkbox"/>	B. MEDICATION/DOSAGE USED:	_____	
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD PRESSURE</b>		
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?	<input type="checkbox"/>	<input type="checkbox"/>	19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?	<input type="checkbox"/>	<input type="checkbox"/>
6. DATE OF LAST EXAMINATION:	_____		A. IF YES, DATE OF LAST TREATMENT:	_____	
<b>HEARING</b>			B. LAST READING:	_____	
7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?	<input type="checkbox"/>	<input type="checkbox"/>	C. MEDICATION/DOSAGE USED:	_____	
8. IS HEARING AID USED?	<input type="checkbox"/>	<input type="checkbox"/>	<b>MISCELLANEOUS</b>		
<b>HEART</b>			20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?	<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"/>
10. HAVE YOU EVER HAD A HEART ATTACK?	<input type="checkbox"/>	<input type="checkbox"/>	22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES?	<input type="checkbox"/>	<input type="checkbox"/>
11. DO YOU HAVE A PACEMAKER?	<input type="checkbox"/>	<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:	_____	
<b>LIMBS</b>			C. LOSS OF EQUILIBRIUM:	_____	
14. HAVE YOU LOST AN ARM OR LEG?	<input type="checkbox"/>	<input type="checkbox"/>	D. ALCOHOL/DRUG ABUSE:	_____	
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?	<input type="checkbox"/>	<input type="checkbox"/>	E. MENTAL/EMOTIONAL ILLNESS:	_____	
16. DOES CAR HAVE SPECIAL CONTROLS?	<input type="checkbox"/>	<input type="checkbox"/>	F. COMPLETE PHYSICAL EXAMINATION:	_____	
<b>DIABETES</b>			24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	<input type="checkbox"/>	<input type="checkbox"/>
17. HAVE YOU EVER BEEN TESTED FOR DIABETES?	<input type="checkbox"/>	<input type="checkbox"/>			
A. LATEST BLOOD SUGAR TEST DATE:	_____				
B. MEDICATION/DOSAGE USED:	_____				
C. METHOD OF ADMINISTRATION:	_____				

**REMARKS**

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

\_\_\_\_\_  
DRIVER'S SIGNATURE

\_\_\_\_\_  
DATE