

ACORD™ 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
EYESIGHT			EPILEPSY		
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"/>	BLOOD PRESSURE		
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:	_____	
HEARING			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"/>	MISCELLANEOUS		
HEART			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:	_____	
LIMBS			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:	_____	
DIABETES			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

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

DRIVER'S SIGNATURE _____

DATE _____