ACORD™ MEDICAL STATEMENT

DATE (MM/DD/YY)

PRODUCER	INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP)
	TELEPHONE NUMBER
CODE: SUBCODE:	CO/PLAN / POL#: / 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
			M F	

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
EYESIGHT		
1. HAVE YOU LOST USE/SIGHT OF EITHER EYE?	☐	☐
2. IS PERIPHERAL (SIDE) VISION RESTRICTED?	☐	☐
3. ARE YOU COLOR BLIND?	☐	☐
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	☐	☐
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?	☐	☐
6. DATE OF LAST EXAMINATION:		
HEARING		
7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?	☐	☐
8. IS HEARING AID USED?	☐	☐
HEART		
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?	☐	☐
10. HAVE YOU EVER HAD A HEART ATTACK?	☐	☐
11. DO YOU HAVE A PACEMAKER?	☐	☐
12. MEDICATION/DOSAGE USED:		
13. WHEN WAS LAST TREATMENT OR CHECK-UP?		
LIMBS		
14. HAVE YOU LOST AN ARM OR LEG?	☐	☐
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?	☐	☐
16. DOES CAR HAVE SPECIAL CONTROLS?	☐	☐
DIABETES		
17. HAVE YOU EVER BEEN TESTED FOR DIABETES?	☐	☐
A. LATEST BLOOD SUGAR TEST DATE:		
B. MEDICATION/DOSAGE USED:		
C. METHOD OF ADMINISTRATION:		

	YES	NO
EPILEPSY		
18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?	☐	☐
A. IF YES, KIND AND DATE OF LAST SEIZURE:		
B. MEDICATION/DOSAGE USED:		
BLOOD PRESSURE		
19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE?	☐	☐
A. IF YES, DATE OF LAST TREATMENT:		
B. LAST READING:		
C. MEDICATION/DOSAGE USED:		
MISCELLANEOUS		
20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?	☐	☐
21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC)?	☐	☐
22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES?	☐	☐
23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE		
A. CONVULSIONS:		
B. FAINTING SPELLS:		
C. LOSS OF EQUILIBRIUM:		
D. ALCOHOL/DRUG ABUSE:		
E. MENTAL/EMOTIONAL ILLNESS:		
F. COMPLETE PHYSICAL EXAMINATION:		
24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	☐	☐

REMARKS

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

DRIVER'S SIGNATURE _____ DATE _____

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