DRIVER'S MEDICAL STATEMENT

NAME OF APPLICANT OR INSURED: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

GENERAL HEALTH

DO YOU HAVE A HISTORY OF:

CONDITION		FIRST DIAGNOSED (YEAR)	REGULARLY TAKING MEDICATION	CONDITION STABILIZED AND/OR UNDER CONTROL
DIABETES	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO
HIGH BLOOD PRESSURE	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO
HEART DISEASE OR ATTACK	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO
EPILEPSY	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO
DIZZY OR FAINTING SPELLS	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO
NEUROMUSCULAR DISEASE	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO
(i.e. muscular dystrophy, multiple sclerosis, cerebral palsy, etc.)				
NEUROLOGICAL , MENTAL OR EMOTIONAL PROBLEMS	❑ YES ❑ NO	_____	❑ YES ❑ NO	❑ YES ❑ NO

HAVE YOU LOST ANY OF THE FOLLOWING?

HANDS ❑ YES ❑ NO ARMS ❑ YES ❑ NO

FEET ❑ YES ❑ NO LEGS ❑ YES ❑ NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, DO YOU USE A PROSTHETIC DEVICE(S)? ❑ YES ❑ NO

IS YOUR VEHICLE EQUIPPED WITH SPECIAL CONTROLS? ❑ YES ❑ NO

HEARING

CAN YOU HEAR AN ORDINARY CONVERSATION WITHOUT A HEARING AID? ❑ YES ❑ NO

IF "NO", EXPLAIN THE EXTENT OF IMPAIRMENT AND CORRECTION TAKEN THAT ENABLES YOU TO HEAR SOUNDS NECESSARY FOR THE SAFE OPERATION OF YOUR VEHICLE. _____

_____

VISION

HAVE YOU LOST THE SIGHT OF EITHER EYE? ❑ YES ❑ NO

ARE YOU COLOR BLIND? ❑ YES ❑ NO

IF "YES" TO ANY OF THE ABOVE, EXPLAIN. _____

_____

MISCELLANEOUS

DO YOU HAVE ANY RESTRICTIONS (OTHER THAN GLASSES) ON YOUR DRIVERS'S LICENSE? ❑ YES ❑ NO

IF "YES", EXPLAIN. _____

_____

ADDITIONAL COMMENTS: _____

_____

REPRESENTATION

I REPRESENT THAT TO THE BEST OF MY KNOWLEDGE ALL THE ANSWERS TO THE ABOVE QUESTIONS ARE TRUE.

_____ _____

Date Applicant or Insured's Signature

AGENT INFORMATION

_____ _____

Agent or Producer's Signature Producer Number