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|---|--|-----------------------|------------------------|--------------------------|--------------------------|---------------------|---------------------|---|--------------------------|-----|-----------------------|------------------------|--------------------------|--------------------|---------------------|--------------------------|------|--|--|--|-------------|--|--|--|--|--|--|--|
| PRODUCER CODE: AGENCY CUSTOMER ID | INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP) <div style="text-align: right;">TELEPHONE NUMBER</div> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SUBCODE: | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">CO/PLAN</td> <td style="width:30%;">POL#:</td> <td style="width:40%;"></td> </tr> <tr> <td></td> <td>ACCT#:</td> <td></td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><input type="checkbox"/></td> <td style="width:10%;">NEW</td> <td style="width:20%;">EFFECTIVE DATE</td> <td style="width:20%;">EXPIRATION DATE</td> <td style="width:10%;"><input type="checkbox"/></td> <td style="width:10%;">DIRECT BILL</td> <td style="width:20%;">PAYMENT PLAN</td> </tr> <tr> <td><input type="checkbox"/></td> <td>RNWL</td> <td></td> <td></td> <td></td> <td>AGENCY BILL</td> <td></td> </tr> </table> </td> <td colspan="6"></td> </tr> </table> | CO/PLAN | POL#: | | | ACCT#: | | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><input type="checkbox"/></td> <td style="width:10%;">NEW</td> <td style="width:20%;">EFFECTIVE DATE</td> <td style="width:20%;">EXPIRATION DATE</td> <td style="width:10%;"><input type="checkbox"/></td> <td style="width:10%;">DIRECT BILL</td> <td style="width:20%;">PAYMENT PLAN</td> </tr> <tr> <td><input type="checkbox"/></td> <td>RNWL</td> <td></td> <td></td> <td></td> <td>AGENCY BILL</td> <td></td> </tr> </table> | <input type="checkbox"/> | NEW | EFFECTIVE DATE | EXPIRATION DATE | <input type="checkbox"/> | DIRECT BILL | PAYMENT PLAN | <input type="checkbox"/> | RNWL | | | | AGENCY BILL | | | | | | | |
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| 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 | |

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|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--|
| 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: | _____ | | | | | | |

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|----------------|
| 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