



Producer Name:		Insured Name and Mailing Address (include county/parish & zip) Date (mm/dd/yy):					
Producer Address:		CO/PLAN			Telephone Number:		
		Pol #:			Acct.#		
Code:	Sub Code:	<input type="checkbox"/> New	Effective Date:	Expiration Date:	<input type="checkbox"/> Direct Bill	Payment Plan	
		<input type="checkbox"/> Renewal			<input type="checkbox"/> Agency Bill		
Agency Customer ID:							
DRIVERS INFORMATION							
Drivers Name:		Date of Birth	Age	Sex	Occupation		
Employers Name and Address		Family Physician's Name and Address		Yrs Under Physicians 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			
VISUAL ACUITY				20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?		<input type="checkbox"/>	<input type="checkbox"/>
Right Eye: _____				21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CERBRAL PALSY, ETC..)?		<input type="checkbox"/>	<input type="checkbox"/>
Left Eye: _____				22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES?		<input type="checkbox"/>	<input type="checkbox"/>
Both Eyes: _____				23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE		_____	
HEART				A. CONVULSIONS:		_____	
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?		<input type="checkbox"/>	<input type="checkbox"/>	B. FAINTING SPELLS		_____	
10. HAVE YOU EVER HAD A HEART ATTACK?		<input type="checkbox"/>	<input type="checkbox"/>	C. LOSS OF EQUILIBRIUM		_____	
11. DO YOU HAVE A PACEMAKER?		<input type="checkbox"/>	<input type="checkbox"/>	D. ALCOHOL/DRUG ABUSE:		_____	
12. MEDICATION/DOSAGE USED:		_____		E. MENTAL/EMOTIONAL ILLNESS:		_____	
13. WHEN WAS LAST TREATMENT OR CHECK-UP?		_____		F. COMPLETE PHYSICAL EXAMINATION:		_____	
LIMBS				24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTION ABOVE:		<input type="checkbox"/>	<input type="checkbox"/>
14. HAVE YOU LOST AN ARM OR LEG?		<input type="checkbox"/>	<input type="checkbox"/>	A. LATEST BLOOD SUGAR TEST DATE:		_____	
15. HAVE YOU LOST THE USE OF AN ARM OR LEG?		<input type="checkbox"/>	<input type="checkbox"/>	B. MEDICATION/DOSAGE USED:		_____	
16. DOES CAR HAVE SPECIAL CONTROLS?		<input type="checkbox"/>	<input type="checkbox"/>	C. METHOD OF ADMINISTRATION:		_____	
DIABETES							
17. HAVE YOU EVER BEEN TESTED FOR DIABETES?		<input type="checkbox"/>	<input type="checkbox"/>				
REMARKS							

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

DRIVERS SIGNATURE: _____

DATE: _____

PHYSICIAN SIGNATURE: _____

DATE: _____