

PRODUCER CODE: AGENCY CUSTOMER ID	INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP) <div style="text-align: right;">TELEPHONE NUMBER</div>														
SUBCODE:	CO/PLAN														
	POL#: ACCT#:														
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"></td> <td style="width:10%;">NEW</td> <td style="width:25%;">EFFECTIVE DATE</td> <td style="width:25%;">EXPIRATION DATE</td> <td style="width:10%;"></td> <td style="width:15%;">DIRECT BILL</td> <td style="width:20%;">PAYMENT PLAN</td> </tr> <tr> <td></td> <td>RNWL</td> <td></td> <td></td> <td></td> <td>AGENCY BILL</td> <td></td> </tr> </table>		NEW	EFFECTIVE DATE	EXPIRATION DATE		DIRECT BILL	PAYMENT PLAN		RNWL				AGENCY BILL	
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	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