DRIVER #: _____

MEDICAL STATEMENT

DATE (MM/DD/YYYY)

AGENCY	CARRIER	NAIC CODE
TMK RISK MANAGEMENT INC		

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)

DRIVER INFORMATION

FIRST NAME	MIDDLE	LAST 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

Y / N

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: _____

Y / N

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 (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

QUESTION #	EXPLANATION

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

DRIVER'S SIGNATURE	DATE (MM/DD/YYYY)