

DRIVER #: _____



MEDICAL STATEMENT

DATE (MM/DD/YYYY) _____

AGENCY TMK RISK MANAGEMENT INC		CARRIER		NAIC CODE
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	
<p>EYESIGHT Y / N</p> <p>1. HAVE YOU LOST USE / SIGHT OF EITHER EYE? <input type="checkbox"/></p> <p>2. IS PERIPHERAL (SIDE) VISION RESTRICTED? <input type="checkbox"/></p> <p>3. ARE YOU COLOR BLIND? <input type="checkbox"/></p> <p>4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS? <input type="checkbox"/></p> <p>5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES / CONTACTS? <input type="checkbox"/></p> <p>6. DATE OF LAST EXAMINATION: _____</p> <p>HEARING Y / N</p> <p>7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL? <input type="checkbox"/></p> <p>8. IS HEARING AID USED? <input type="checkbox"/></p> <p>HEART Y / N</p> <p>9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE? <input type="checkbox"/></p> <p>10. HAVE YOU EVER HAD A HEART ATTACK? <input type="checkbox"/></p> <p>11. DO YOU HAVE A PACEMAKER? <input type="checkbox"/></p> <p>12. MEDICATION / DOSAGE USED: _____</p> <p>13. WHEN WAS LAST TREATMENT OR CHECK-UP? _____</p> <p>LIMBS Y / N</p> <p>14. HAVE YOU LOST AN ARM OR LEG? <input type="checkbox"/></p> <p>15. HAVE YOU LOST THE USE OF AN ARM OR A LEG? <input type="checkbox"/></p> <p>16. DOES CAR HAVE SPECIAL CONTROLS? <input type="checkbox"/></p> <p>DIABETES Y / N</p> <p>17. HAVE YOU EVER BEEN TESTED FOR DIABETES? <input type="checkbox"/></p> <p>A. LATEST BLOOD SUGAR TEST DATE: _____</p> <p>B. MEDICATION / DOSAGE USED: _____</p> <p>C. METHOD OF ADMINISTRATION: _____</p>	<p>EPILEPSY Y / N</p> <p>18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY? <input type="checkbox"/></p> <p>A. IF YES, KIND AND DATE OF LAST SEIZURE: _____</p> <p>B. MEDICATION / DOSAGE USED: _____</p> <p>BLOOD PRESSURE</p> <p>19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE? <input type="checkbox"/></p> <p>A. IF YES, DATE OF LAST TREATMENT: _____</p> <p>B. LAST READING: _____</p> <p>C. MEDICATION / DOSAGE USED: _____</p> <p>MISCELLANEOUS</p> <p>20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM? <input type="checkbox"/></p> <p>21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC)? <input type="checkbox"/></p> <p>22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES? <input type="checkbox"/></p> <p>23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE</p> <p>A. CONVULSIONS: _____</p> <p>B. FAINTING SPELLS: _____</p> <p>C. LOSS OF EQUILIBRIUM: _____</p> <p>D. ALCOHOL / DRUG ABUSE: _____</p> <p>E. MENTAL / EMOTIONAL ILLNESS: _____</p> <p>F. COMPLETE PHYSICAL EXAMINATION: _____</p> <p>24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE? <input type="checkbox"/></p>

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)
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