ACORD™ MEDICAL STATEMENT

DATE

PRODUCER

HULL MAYNARD HERSEY INS.
105 Center Street
P.O. Box 550
Rutland, VT 05702

CODE: SUBCODE:

AGENCY CUSTOMER ID

INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP)

TELEPHONE NUMBER

CO/PLAN

POL#:

ACCT#:

	NEW / RNWL	EFFECTIVE DATE	EXPIRATION DATE		DIRECT BILL / AGENCY BILL	PAYMENT PLAN

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
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: _____		

	YES	NO
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

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

DRIVER'S SIGNATURE _____ DATE _____

ELECTRONIC LASER FORMS, INC. - (800)327-0545