AGENCY CUSTOMER ID: Agency Customer Id

DRIVER #: Driver Number

ACORD®

MEDICAL STATEMENT

DATE (MM/DD/YYYY): 07/27/2024

AGENCY	CARRIER	NAIC CODE
Agency Name	Carrier Name	NAIC Code

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)
Policy Number	07/27/2024	Robin W. Smith

DRIVER INFORMATION

FIRST NAME	MIDDLE	LAST NAME	DATE OF BIRTH	AGE	SEX	OCCUPATION
Robin	W	Smith	07/27/2024	12, 345	Driver Gender	Driver Occupation

EMPLOYER'S NAME AND ADDRESS	FAMILY PHYSICIAN'S NAME AND ADDRESS	YRS UNDER PHYSICIAN CARE	DATE OF LAST VISIT
Employer Name 123 Main St #234 San Francisco CA, 94106	Robin W. Smith 123 Main St #234 San Francisco CA, 94106	12, 345	07/27/2024

DRIVER MEDICAL HISTORY

EXPLAIN ALL "YES" RESPONSES IN REMARKS - INCLUDE CONDITION AND EXPLANATION

Within the past five (5) years, have you had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

EYESIGHT	Y / N
LOSS OF USE / SIGHT OF EITHER EYE	EyeSight-Loss Of Use
RESTRICTED PERIPHERAL (SIDE) VISION	EyeSight-Restricted Peripheral (Side) Vision
COLOR BLINDNESS	EyeSight-Color Blindness
CATARACTS	EyeSight-Cataracts
CORRECTIVE LENSES / CONTACTS	EyeSight-Corrective Lenses / Contacts
DATE OF LAST EYE EXAMINATION:	07/27/2024

HEARING	
LOSS OF HEARING	Hearing-Loss Of Hearing
HEARING AID	Hearing-Hearing Aid

HEART	
HEART DISEASE	Heart-Heart Disease
HEART ATTACK	Heart-Heart Attack
PACEMAKER	Heart-Pacemaker
MEDICATION / DOSAGE USED:	Heart-Medication Or Dosage Used
DATE OF LAST TREATMENT OR CHECK-UP:	07/27/2024

LIMBS	
LOSS OF ARM OR LEG	Limbs-Loss Of Arm OR Leg
LOSS OF USE OF AN ARM OR A LEG	Limbs-Loss Of Use Of An Arm OR Leg
DOES CAR HAVE SPECIAL CONTROLS?	Limbs-Does Car Have Special Controls

DIABETES	
DIABETES	Diabetes
LATEST BLOOD SUGAR TEST DATE:	07/27/2024
MEDICATION / DOSAGE USED:	Diabetes-Medication Or Dosage Used
METHOD OF ADMINISTRATION:	Diabetes-Method Of Administration

EPILEPSY	Y / N
EPILEPSY	Epilepsy
KIND OF EPILEPSY:	Epilepsy-Kind Of Epilepsy
DATE OF LAST SEIZURE:	07/27/2024
MEDICATION / DOSAGE USED:	Epilepsy-Medication Or Dosage Used

BLOOD PRESSURE	
HIGH BLOOD PRESSURE	Blood Pressure-High Blood P
DATE OF LAST TREATMENT:	07/27/2024
LAST READING:	Blood Pressure-Last Reading
MEDICATION / DOSAGE USED:	Blood Pressure-Medication Or Dosage Used

MISCELLANEOUS	
NEUROLOGICAL IMPAIRMENT	Miscellaneous-Neurological Im
NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, etc)	Miscellaneous-Neuromuscular
DRIVERS LICENSE RESTRICTIONS OTHER THAN GLASSES	Miscellaneous-Driver License R
DATE OF LAST TREATMENT, IF APPLICABLE:	
CONVULSIONS:	07/27/2024
FAINTING SPELLS:	07/27/2024
LOSS OF EQUILIBRIUM:	07/27/2024
ALCOHOL / DRUG ABUSE:	07/27/2024
MENTAL / EMOTIONAL ILLNESS:	07/27/2024
ANY EXISTING CONDITION NOT MENTIONED ABOVE	Miscellaneous-Not Mentioned
DATE OF LAST COMPLETE PHYSICAL EXAMINATION:	07/27/2024

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

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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)