



MEDICAL STATEMENT

DATE (MM/DD/YYYY)
05/17/2024

AGENCY <u>Agency Name</u>		CARRIER <u>Carrier Name</u>		NAIC CODE <u>NAIC Code</u>
POLICY NUMBER <u>Policy Number</u>	EFFECTIVE DATE <u>05/17/2024</u>	NAMED INSURED(S) <u>Robin W. Smith</u>		

DRIVER INFORMATION

FIRST NAME <u>Robin</u>	MIDDLE <u>W</u>	LAST NAME <u>Smith</u>	DATE OF BIRTH <u>05/17/2024</u>	AGE <u>345</u>	SEX <u>Driver Gender</u>	OCCUPATION <u>Driver Occupation</u>
EMPLOYER'S NAME AND ADDRESS <u>Employer Name</u> <u>123 Main St #234</u> <u>San Francisco CA, 94106</u>		FAMILY PHYSICIAN'S NAME AND ADDRESS <u>Robin W. Smith</u> <u>123 Main St #234</u> <u>San Francisco CA, 94106</u>			YRS UNDER PHYSICIAN CARE <u>12</u> <u>345</u>	DATE OF LAST VISIT <u>05/17/2024</u>

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

LOSS OF USE / SIGHT OF EITHER EYE
RESTRICTED PERIPHERAL (SIDE) VISION
COLOR BLINDNESS
CATARACTS
CORRECTIVE LENSES / CONTACTS

Y / N
EyeSight-Loss Of Use
EyeSight-Restricted Peripheral (Side) Vision
EyeSight-Color Blindness
EyeSight-Cataracts
EyeSight-Corrective Lenses
DATE OF LAST EYE EXAMINATION: 05/17/2024

EPILEPSY

Y / N
Epilepsy
EPILEPSY
EPILEPSY: Epilepsy-Kind Of Epilepsy
DATE OF LAST SEIZURE: 05/17/2024
MEDICATION / DOSAGE USED: Epilepsy-Medication Or Dosage Used

HEARING

LOSS OF HEARING
HEARING AID

Hearing-Loss Of Hearing
Hearing-Hearing Aid

BLOOD PRESSURE

HIGH BLOOD PRESSURE
DATE OF LAST TREATMENT: 05/17/2024
LAST READING: Blood Pressure-Last Reading
MEDICATION / DOSAGE USED: Blood Pressure-Medication Or Dosage Used

HEART

HEART DISEASE
HEART ATTACK
PACEMAKER

Heart-Heart Disease
Heart-Heart Attack
Heart-Pacemaker

MISCELLANEOUS

NEUROLOGICAL IMPAIRMENT
NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, etc)
DRIVERS LICENSE RESTRICTIONS OTHER THAN CLASS B
Miscellaneous-Neurological Imp
Miscellaneous-Neuromuscular
Miscellaneous-Driver License R

MEDICATION / DOSAGE USED: Heart-Medication Or Dosage Used
DATE OF LAST TREATMENT OR CHECK-UP: 05/17/2024

LIMBS

LOSS OF ARM OR LEG
LOSS OF USE OF AN ARM OR A LEG
DOES CAR HAVE SPECIAL CONTROLS?

Limbs-Loss Of Arm OR Leg
Limbs-Loss Of Use Of An Arm OR Leg
Limbs-Does Car Have Special Controls

DATE OF LAST TREATMENT, IF APPLICABLE:
CONVULSIONS: 05/17/2024
FAINTING SPELLS: 05/17/2024
LOSS OF EQUILIBRIUM: 05/17/2024
ALCOHOL / DRUG ABUSE: 05/17/2024
MENTAL / EMOTIONAL ILLNESS: 05/17/2024

DIABETES

DIABETES

Diabetes

LATEST BLOOD SUGAR TEST DATE: 05/17/2024
MEDICATION / DOSAGE USED: Diabetes-Medication Or Dosage Used
METHOD OF ADMINISTRATION: Diabetes-Method Of Administration

ANY EXISTING CONDITION NOT MENTIONED ABOVE Miscellaneous-Not Mentioned
DATE OF LAST COMPLETE PHYSICAL EXAMINATION: 05/17/2024

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

Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor.

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)