

PRODUCER		NAME AND MAILING ADDRESS (INCLUDE ZIP CODE)					
CODE	SUB CODE	COMPANY / PLAN	POLICY NUMBER		NEW	EFFECTIVE DATE	EXPIRATION DATE
				REN'L			

**GENERAL INFORMATION**

DATE OF BIRTH	AGE	SEX	OCCUPATION	EMPLOYER'S NAME AND ADDRESS		
NAME OF FAMILY DOCTOR AND ADDRESS					YRS. UNDER PHY. CARE	DATE OF LAST VISIT

**MEDICAL HISTORY**

<p><b>EYESIGHT</b></p> <table style="width:100%;"> <tr> <td style="width:50%;"></td> <td style="width:5%; text-align:center;">YES</td> <td style="width:5%;"></td> <td style="width:5%; text-align:center;">NO</td> <td style="width:5%;"></td> </tr> <tr> <td>1. HAVE YOU LOST USE/SLIGHT OF EITHER EYE?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="border-left: 1px solid black;"></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>2. IS PERIPHERAL (SIDE) VISION RESTRICTED?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="border-left: 1px solid black;"></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>3. ARE YOU COLOR BLIND?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="border-left: 1px solid black;"></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="border-left: 1px solid black;"></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="border-left: 1px solid black;"></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>6. DATE OF LAST EYE EXAMINATION</td> <td colspan="4" style="text-align:center;">_____</td> </tr> </table>		YES		NO		1. HAVE YOU LOST USE/SLIGHT OF EITHER EYE?	<input type="checkbox"/>		<input type="checkbox"/>		2. IS PERIPHERAL (SIDE) VISION RESTRICTED?	<input type="checkbox"/>		<input type="checkbox"/>		3. ARE YOU COLOR BLIND?	<input type="checkbox"/>		<input type="checkbox"/>		4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS?	<input type="checkbox"/>		<input type="checkbox"/>		5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?	<input type="checkbox"/>		<input type="checkbox"/>		6. DATE OF LAST EYE EXAMINATION	_____				<p><b>DIABETES</b></p> <table style="width:100%;"> <tr> <td style="width:50%;"></td> <td style="width:5%; text-align:center;">YES</td> <td style="width:5%;"></td> <td style="width:5%; text-align:center;">NO</td> <td style="width:5%;"></td> </tr> <tr> <td>1. HAVE YOU EVEN BEEN TESTED FOR DIABETES?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="border-left: 1px solid black;"></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>2. LATEST BLOOD/SUGAR TEST DATE</td> <td colspan="4" style="text-align:center;">_____</td> </tr> <tr> <td>3. MEDICATION/DOSAGE USED</td> <td colspan="4" style="text-align:center;">_____</td> </tr> <tr> <td>4. METHOD OF ADMINISTRATION</td> <td colspan="4" style="text-align:center;">_____</td> </tr> </table>		YES		NO		1. HAVE YOU EVEN BEEN TESTED FOR DIABETES?	<input type="checkbox"/>		<input type="checkbox"/>		2. LATEST BLOOD/SUGAR TEST DATE	_____				3. MEDICATION/DOSAGE USED	_____				4. METHOD OF ADMINISTRATION	_____			
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(IF ANY "YES" RESPONSES, PLEASE PROVIDE COMPLETE EXPLANATION)		YES	NO
1. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?	<input type="checkbox"/>		<input type="checkbox"/>
2. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC.)?	<input type="checkbox"/>		<input type="checkbox"/>
3. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVER'S LICENSE OTHER THAN GLASSES?	<input type="checkbox"/>		<input type="checkbox"/>
4. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	<input type="checkbox"/>		<input type="checkbox"/>

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