Z A S
Zurich Agency Services

DRIVER HEALTH QUESTIONNAIRE

NAME OF INSURED OR APPLICANT:____
BIRTHDATE:_________________________ POLICY NUMBER:_________________________

DRIVER INFORMATION

1. DESCRIBE USE OF AUTOMOBILE		2. HOW LONG HAS OPERATOR HAD A LICENSE?
3. DATE LAST LICENSE EXAMINATION	4. ESTIMATED NUMBER OF TRIPS IN EXCESS OF 100 MILES TAKEN ANNUALLY	5. APPROXIMATE ANNUAL MILEAGE DRIVEN
6. PERCENTAGE OF NIGHT DRIVING	7. LIST MOVING VIOLATIONS AND ACCIDENTS DURING THE PAST THREE YEARS	

8. DO YOU HAVE A RESTRICTED LICENSE, OTHER THEN CORRECTIVE LENSES? ❑ YES ❑ NO
IF YES, PLEASE DESCRIBE RESTRICTION____
____

9. HAS THE AUTOMOBILE BEEN ALTERED TO COMPENSATE FOR ANY IMPAIRMENT(S)? (HAND CONTROLS, AUTOMATIC TRANSMISSION, ADDITIONAL REAR-VIEW MIRRORS, GAS PEDAL MOVED TO THE LEFT, ETC..) ❑ YES ❑ NO
IF YES, PLEASE DESCRIBE RESTRICTION____
____

10. DO YOU HAVE ANY MEDICALLY-IMPOSED, COURT-IMPOSED, OR STATE-IMPOSED RESTRICTIONS ON YOUR DRIVING?❑ YES ❑ NO
IF YES, PLEASE EXPLAIN____
____

MEDICAL INFORMATION

1. DO YOU HAVE OR ARE YOU BEING TREATED FOR ANY OF THE FOLLOWING?
IF YES, PLEASE EXPLAIN, BEING SURE TO INCLUDE TYPE AND QUANTITY OF MEDICATION
A. DIZZY OR FAINTING SPELLS ❑ YES ❑ NO
B. DIABETES ❑ YES ❑ NO
C. EPILEPSY ❑ YES ❑ NO
D. HIGH BLOOD PRESSURE ❑ YES ❑ NO
E. IF YOU HAVE RECENTLY HAD AN EXAMINATION BY YOUR PHYSICIAN AND KNOW YOUR APPROXIMATE BLOOD PRESSURE, PLEASE INDICATE.______________________

2. HAVE YOU ANY OTHER SERIOUS ILLNESSES FOR WHICH YOU ARE RECEIVING MEDICAL ATTENTION? ❑ YES ❑ NO
IF YES, EXPLAIN. PLEASE GIVE DATE(S) AND DEGREE OF CONTROL (INCLUDING TYPE AND QUANTITY OF MEDICATION TAKEN).____
____
____

3. HAVE YOU HAD A HEART ATTACK OR A STROKE? ❑ YES ❑ NO
IF YES, WHEN?____

4. HAVE YOU BEEN ADVISED BY A PHYSICIAN TO RESTRICT YOUR ACTIVITIES? ❑ YES ❑ NO
IF YES, EXPLAIN____

5. DO YOU HAVE LESS THEN FULL USE OF BOTH ARMS AND LEGS? ❑ YES ❑ NO
IF YES, EXPLAIN____

6. ARE YOU TAKING MEDICATION WHICH MIGHT AFFECT YOUR DRIVING? ❑ YES ❑ NO
IF YES, EXPLAIN____

7. DO YOU HAVE ANY IMPAIRMENT OF EYESIGHT OR HEARING? ❑ YES ❑ NO
IF YES, EXPLAIN____

8. HAVE YOU BEEN ADVISED THAT YOU MAY HAVE CATARACTS? ❑ YES ❑ NO
HAS YOUR DOCTOR ADVISED YOU THAT AN OPERATION IS NECESSARY? ❑ YES ❑ NO
IF YES, WHEN?____

9. APPROXIMATE DATE OF YOUR LAST EYE EXAMINATION:______________________
WHAT WAS YOUR LAST ACUITY RATING?
LEFT 20/______ RIGHT 20/______ ❑ CORRECTED ❑ UNCORRECTED

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I CERTIFY THAT THE ABOVE INFORMATION TO BE TRUE AND CORRECT

____ ____________________

SIGNATURE OF INSURED OR APPLICANT **DATE**