American Reliable
Insurance Company

Driver Self-Appraisal Form

Policy Number:

Name of Driver: _____ Date of Birth: _____

Marital Status: _____ Operator's (driver's) License No.: _____

How Long Licensed?: _____ Date of Last Examination?: _____

Date Current License Expires?: _____ Do You Wear Glasses?: _____

Please answer these questions:

		Explain any "Yes" Answer In Remarks YES	NO
1.	Have you been convicted of a moving traffic violation in the past 3 years?	☐	☐
2.	Have you been involved in an auto accident in the past 3 years?	☐	☐
3.	Approximately how many miles do you drive each year?	☐	☐
4.	What percentage of your driving is done on vacations and on trips in excess of 100 miles? _____		
5.	Date of you last physical examination? _____		
6.	Do you have any impairments? (vision, hearing, heart, diabetes, muscular, or others?)	☐	☐
7.	What is your vision or corrected vision if you wear glasses? Right eye: _____ Left eye: _____		
8.	Do you have fainting spells, dizzy spells, strokes, attacks of unconsciousness, or convulsions?	☐	☐
9.	Have you ever had a heart attack or a heart condition requiring treatment?	☐	☐
10.	Have you ever been treated for high blood pressure?	☐	☐
11.	Have you been hospitalized or undergone medical treatment in the past 5 years?	☐	☐
12.	Have you ever been advised by anyone to restrict your driving?	☐	☐
13.	Do you practice any self-imposed restrictions on your driving?	☐	☐

REMARKS: (Identify by question number.)

_____

_____

_____

_____

I declare to the best of my knowledge these statements are true and complete:

_____

Signature of Driver