



DRIVING QUESTIONNAIRE

Name: _____ Date of Birth: _____

Cigarette Smoker: Yes No Quantity per day: _____

Occupation: _____

1. Do you currently hold a valid driver's license? Yes No

If yes, State: _____

License number: _____ Expiration date: _____

If no, date of suspension: _____ Length of suspension: _____

2. List all speeding violations within the last five years:

Month / year _____ Amount over limit: _____

Month / year _____ Amount over limit: _____

Month / year _____ Amount over limit: _____

Month / year _____ Amount over limit: _____

3. List all moving violations other than speeding within the last five years:

Month / year _____ Violation: _____

Month / year _____ Violation: _____

Month / year _____ Violation: _____

Month / year _____ Violation: _____

4. List all accidents involving property damage within the last five years:

Month / year: _____

Month / year: _____

Month / year: _____

5. Have you ever been treated for alcohol or substance abuse? Yes No

If yes, Month / year _____ Where? _____

Notes/comments: _____

Agent: _____

Address: _____

Phone: _____ Fax: _____

Signature of Proposed Insured: _____ Date: _____