



### 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: \_\_\_\_\_