KINSALE INSURANCE

Kinsale Insurance Company
P.O. Box 17008
Richmond, VA 23236
(804) 289-1300
www.kinsaleins.com

AGING PROVIDER SUPPLEMENT

Instructions to the Applicant – Please complete this supplement in ink and answer all questions completely. If space is not sufficient to properly answer a question, please attach a separate page. Sign and date supplement upon completion.

PERSONAL INFORMATION

Applicant's Name and Degree Designation(s): ______________________________

Social Security Number: ________ - ______ - ________ Date of Birth _____ / _____ / ________

Practice Address: ______________________________
STREET CITY COUNTY STATE ZIP

Mailing Address: ______________________________
STREET CITY COUNTY STATE ZIP

EYESIGHT

Have you lost use or sight of either eye? ☐ YES ☐ NO

Is peripheral vision restricted? ☐ YES ☐ NO

Are you color blind? ☐ YES ☐ NO

Do you have or have you ever had cataracts? ☐ YES ☐ NO

Are deficiencies corrected by glasses/contacts? ☐ YES ☐ NO

Date of last eye exam: ____________________

HEARING

Are you able to hear normal conversation levels? ☐ YES ☐ NO

Do you use a hearing aid? ☐ YES ☐ NO

HEART

Have you ever been treated for heart disease? ☐ YES ☐ NO

Have you ever had a heart attack? ☐ YES ☐ NO

Do you have a pacemaker? ☐ YES ☐ NO

List of medications/dosage used:

____

Date of last treatment/exam (mm/yy):________

DIABETES

Have you ever been tested for diabetes? ☐ YES ☐ NO

Medication/dosage:____________________

Methods of administration: ________________

____

BLOOD PRESSURE

Have you ever been treated for hypertension? ☐ YES ☐ NO

If yes, date of last treatment: ________________

Most current reading: ____________________

Medication/dosage used:

____

EPILEPSY

Have you ever been treated for epilepsy? ☐ YES ☐ NO

Kind and date of seizure: ________________

Medication/dosage used:

____

MISCELLANEOUS

Have you ever been treated or received medication for any neuromuscular disease, e.g., muscular dystrophy, multiple sclerosis, cerebral palsy, etc.? ☐ YES ☐ NO

Are there any restrictions on your driver's license other than corrective lenses? ☐ YES ☐ NO

Date of last treatment, if applicable, for:

Convulsions ___________

Fainting Spells ___________

Loss of Equilibrium ___________

Alcohol/Substance Abuse ___________

Complete Physical Examination ___________

Are you under a physician's care for any condition not mentioned above? ☐ YES ☐ NO

If yes, please describe below.

____

____

Signature: ______________________________

Printed Name: ______________________________

Date: ______________________________