Kinsale Insurance Company
P.O. Box 17008
Richmond, VA 23236
(804) 289-1300
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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?
If yes, date of last treatment: _____ ☐ YES ☐ NO
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: _____