PART2

ShowRequest.java

```
import java.io.IOException;
import javax.servlet.ServletException;
import java.io.PrintWriter;
import javax.servlet.http.HttpServlet;
import javax.servlet.http.HttpServletResponse;
import javax.servlet.http.HttpServletRequest;
import java.util.Enumeration;



public  class ShowRequest extends HttpServlet{
        public void doGet(HttpServletRequest req,HttpServletResponse res)throws
ServletException,IOException{
                res.setContentType("text/html");
                PrintWriter out=res.getWriter();
                out.println("<html>");
                out.println("<head><title>This is the first lab</title></head>");
                out.println("<body bgcolor='gray'><b>Request URI:</b>"+req.getRequestURI());
                out.println("<hr>");
                out.println("<table>");
                Enumeration headers=req.getHeaderNames();
                while(headers.hasMoreElements())
                {
                        String header=(String)headers.nextElement();
                        //out.println("<p>headers are here</p>");
```

```
                out.println("<tr><td>"+header+"</td>");
                out.println("<td>"+req.getHeader(header)+"</td></tr>");

            }
            //out.println("<p>header value</p>");
            String headerValue = req.getHeader(req.getHeaderNames().nextElement());
            out.print("Header Value:" + headerValue);
            out.println("</table>");
            out.println("</body>");
            out.println("</html>");
        }

        public void doPost(HttpServletRequest req,HttpServletResponse res)throws
ServletException,IOException{
            doGet(req,res);
        }
}
```

WEB.XML

```
<web-app>
    <servlet>
        <servlet-name>lab1</servlet-name>
        <servlet-class>ShowRequest</servlet-class>
    </servlet>

    <servlet-mapping>
        <servlet-name>lab1</servlet-name>
        <url-pattern>/ShowRequest</url-pattern>
```

```
        </servlet-mapping>
</web-app>
```

PART 3.2

form.java

```
import java.io.IOException;
import javax.servlet.ServletException;
import java.io.PrintWriter;
import javax.servlet.http.HttpServlet;
import javax.servlet.http.HttpServletResponse;
import javax.servlet.http.HttpServletRequest;
import java.util.Enumeration;



public  class form extends HttpServlet{



        public void doPost(HttpServletRequest req,HttpServletResponse res)throws
ServletException,IOException{
                res.setContentType("text/html");
                PrintWriter out=res.getWriter();
                out.println("<html>");
                out.println("<head><title>This is the form</title></head>");
                out.println("<body bgcolor='gray'><b>Request URI:</b>"+req.getRequestURI());
                out.println("<hr>");
                out.println("<label><h2>1.General Information</h2></label>");
```

```
                out.println("<label><h3>Your Information:</h3></label>");

        out.println("<label><h4>Name:</h4></label>"+req.getParameter("cust_name")+"<br>");
                out.println("Address:"+req.getParameter("address")+"<br>");
                out.println("City,State,Zip:"+req.getParameter("city_state_zip"));
                out.println("Phone:"+req.getParameter("phone")+"<br>");
                out.println("Email:"+req.getParameter("email")+"<br>");

                out.println("<label><h3>Pet Information:</h3></label>"+"<br>");
                out.println("Account No:"+req.getParameter("account_No")+"<br>");
                out.println("Pet Name:"+req.getParameter("pet_name")+"<br>");
                out.println("Breed:"+req.getParameter("breed")+"<br>");
                out.println("Age:"+req.getParameter("age")+"<br>");
                out.println("Gender:"+req.getParameter("gender")+"<br>");

                out.println("<label><h2>2.Daignosy/Symptom Information</h2></label>"+"<br>");
                out.println("<label><h4>Story of Occurence/Diagnosis</h4</label>"+"<br>");
                out.println(req.getParameter("comment")+"<br>");
                out.println("<label><h4>The claim is related
to:</h4</label>"+req.getParameter("accident")+"<br>");
                out.println("Veternarian"+req.getParameter("veternarian")+"<br>");
                out.println("<label><h4>is this claim is estimate for future
treatment?</h4></label>"+req.getParameter("accident1")+"<br>");
                out.println("<label><h4>Clinic
Name:</h4></label>"+req.getParameter("clinic_name")+"<br>");
                out.println("<label><h4>Total amount
claimed:</h4</label>"+req.getParameter("amnt_claim")+"<br>");
                out.println("Phone:"+req.getParameter("phone1")+"<br>");
                out.println("Fax:"+req.getParameter("fax")+"<br>");
                out.println("<label><h4>Date illness/injury first
occured:</h4</label>"+req.getParameter("amnt_claim")+"<br>");
```

```
                out.println("<label><h4>Did any veternarian treat you
pet?:</h4></label>"+req.getParameter("veterinarian1")+"<br>");

                out.println("<label><h4>Send payment to
:</h4</label>"+req.getParameter("me")+"<br>");

                out.println("<label><h4>Is this new
condition?:</h4></label>"+req.getParameter("condition")+"<br>");

                out.println("<label><h2>3.Pet Owner Declaration:</h2></label>"+"<br>");

                out.println("<label><h6>I confirm to the best of my knowledge the above statements
are true in every respect. I understand that the fees listed may not be covered or may exceed my plan
benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I
understand that this claim cannot be adjusted without itemized receipts. I also understand that the
deliberate misrepresentation of the animal's condition or the omission of any material facts may result
in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance
Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance
claim records and medical records as to examination, history, diagnosis, treatment and prognosis with
respect to any condition. I further authorize these entities to disclose identifying information about me
and my pet, as well as information about my claim experience, to my
veterinarian.</h6></label>"+"<br>");

                out.println("<label><h4>Signature of pet
owner:</h4></label>"+req.getParameter("sign")+"<br>");

                out.println("Date:"+req.getParameter("date")+"<br>");









                out.println("</body>");

                out.println("</html>");

        }

}
```

form.html

```
<!DOCTYPE html>
```

```
<html lang="en">
<head>
  <title>Pre-Insurance-Claim-Form</title>
  <meta charset="utf-8">
  <meta name="viewport" content="width=device-width, initial-scale=1">
  <link rel="stylesheet" href="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css">
  <script src="https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js"></script>
  <script src="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js"></script>

  <!-- Include jQuery -->
<script type="text/javascript" src="https://code.jquery.com/jquery-1.11.3.min.js"></script>

<!-- Include Date Range Picker -->
<script type="text/javascript" src="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.js"></script>
<link rel="stylesheet" href="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css"/>
  <style>
.story_occure{border-style: solid;}


</style>
</head>
<body>

<div class="container">

  <form class="form-horizontal" id="ins_form" action="form" method="post">
        <div class="row form-inline">
```

```
                <div class="col-md-12">
                        <div class="col-md-4">
                                <label><h2>1.General Information</h2></label>
                        </div>
                        <div class="bottom-aligned-text col-md-8">
                                <label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>
                        </div>
                </div>
                <hr>
        </div>
        <b><hr></b>
         <div class="row form-inline">
                <div class="col-md-6">
                        <label><h3>Your Information:</h3></label>
                 </div>
                <div class="col-md-6">
                        <label><h3>Pet Information:</h3></label>
                </div>

        </div>

         <div class="row form-inline">
                <div class="col-md-6">
                        <label><h4>Name:</h4></label>

                                        <input type="text" class="form-control" name="cust_name">

                 </div>
```

```
        <div class="col-md-6">
                <label><h4>Account No:</h4></label>
                <input type="text" class="form-control" name="account_No">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
                <label><h4>Address:</h4></label>
                 <input type="text" class="form-control" name="address">
         </div>

        <div class="col-md-6">
                <label><h4>Name:</h4></label>
                <input type="text" class="form-control" name="pet_name">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
                <label><h4>City,State,Zip:</h4></label>
                 <input type="text" class="form-control" name="city_state_zip">
         </div>

        <div class="col-md-6">
                <label><h4>Breed:</h4></label>
```

```
                <input type="text" class="form-control" name="breed">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
                <div class="col-md-6">
                        <label><h4>Phone:</h4></label>
                        <input type="text" class="form-control" name="phone">
                </div>
                <div class="col-md-6">
                        <label><h4>Email:</h4></label>
                        <input type="text" class="form-control" name="email">
                </div>
         </div>

        <div class="col-md-6">
                <div class="col-md-6">
                        <label><h4>Age:</h4></label>
                        <input type="text" class="form-control" name="age">
                </div>
                <div class="col-md-6">
                        <label><h4>Gender:</h4></label>
                        <input type="text" class="form-control" name="gender">
                </div>
        </div>

</div><!--end of 1st section-->
```

```
<div class="row form-inline">
    <div class="col-md-12">
        <div class="col-md-6">
            <label><h2>2.Daignosy/Symptom Information</h2></label>
        </div>
        <div class="bottom-aligned-text col-md-6">
            <label><h6><i>HELP US! By providing the "Story of Occurrence of Daignosy" you will help us avoid processind your delays</i></h6></label>
        </div>
    </div>
</div>

<hr>

<div class="story_occure">
<div class="row form-inline">
    <div class="col-md-12">
        <div class="col-md-6">
            <label><h4>Story of Occurence/Diagnosis</h4</label>
        </div>
        <div class="bottom-aligned-text col-md-6">
            <label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>
        </div>
        <div class="col-md-12">
            <textarea class="form-control" rows="3" name="comment"></textarea>
```

```
                </div>
            </div>

</div>
</div>

<div class="row form-inline">

                <div class="col-md-6">
                    <label><h4>The claim is related to:</h4</label>
                    <input type="checkbox" name="accident" value="Accident">Accident
                    <input type="checkbox" name="accident" value="Illness">Illness
                    <input type="checkbox" name="accident" value="Wellness">Wellness
                </div>
                <div class="col-md-6">
                    <label><h4>Veternarian</h4></label>
                    <input type="text" class="form-control" name="veternarian">
                </div>



</div>

<div class="row form-inline">

                <div class="col-md-6">
                    <label><h4>is this claim is estimate for future treatment?</h4</label>
                    <input type="checkbox" name="accident1" value="Yes">Yes
                    <input type="checkbox" name="accident1" value="No">No
```

```
                </div>
                <div class="col-md-6">
                        <label><h4>Clinic Name:</h4></label>
                        <input type="text" class="form-control" name="clinic_name">
                </div>


</div>

<div class="row form-inline">

                <div class="col-md-6">
                        <label><h4>Total amount claimed:</h4</label>
                        <input type="text" class="form-control" name="amnt_claim">

                </div>
                <div class="col-md-6">
                        <label><h4>Phone:</h4></label>
                        <input type="text" class="form-control" name="phone1">
                        <label><h4>Fax:</h4></label>
                        <input type="text" class="form-control" name="fax">

                </div>


</div>

<div class="row form-inline">
```

```
                    <div class="col-md-6">
                        <label><h4>Date illness/injury first occured:</h4</label>
                        <input type="text" class="form-control" name="amnt_claim">

                    </div>
                    <div class="col-md-6">
                        <label><h4>Did any veternarian treat you pet?:</h4></label>
                        <input type="checkbox" class="form-control" name="veterinarian1"
value="Yes">Yes
                        <input type="checkbox" class="form-control" name="veterinarian1"
value="No">No

                    </div>


    </div>

    <div class="row form-inline">

                    <div class="col-md-6">
                        <label><h4>Send payment to :</h4</label>
                        <input type="checkbox" class="form-control" name="me"
value="Me">Me
                        <input type="checkbox" class="form-control" name="me"
value="Veternarian">Veternarian
                    </div>
                    <div class="col-md-6">
                        <label><h4>Is this new condition?:</h4></label>
                        <input type="checkbox" class="form-control" name="condition"
value="Yes">Yes
```

<input type="checkbox" class="form-control" name="condition" value="No">No

<!--end of 2nd -->

<label><h2>3.Pet Owner Declaration:</h2></label>

<hr>

<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.

</h6></label>

```
            </div>
        </div>

        <div class="row form-inline">

                    <div class="col-md-6">
                        <label><h4>Signature of pet owner:</h4></label>
                        <input type="text" class="form-control" name="sign">

                    </div>



                    <div class="col-md-6 date">
                                <label class="control-label" for="date">Date</label>
                                 <div class="input-group input-append date"
id="dateRangePicker">
                                    <input class="form-control" id="date" name="date"
placeholder="MM/DD/YYY" type="text"/>
                                    <span class="input-group-addon add-on"><span
class="glyphicon glyphicon-calendar"></span></span>
                                </div>
                    </div>
        </div>

        <div class="row form-inline">
            <div class="col-md-6">
                <button type="submit" class="btn btn-default">Submit</button>
            </div>
```

```
            </div>
            <!-------------------------------------------------------------------------------------------------------->
    <script>
$(document).ready(function() {
    $('#dateRangePicker')
        .datepicker({
            format: 'mm/dd/yyyy',
            startDate: '01/01/2010',
            endDate: '12/30/2020'
        })
        .on('changeDate', function(e) {
            // Revalidate the date field
            $('#ins_form').formValidation('revalidateField', 'date');
        });

    $('#ins_form').formValidation({
        framework: 'bootstrap',
        icon: {
            valid: 'glyphicon glyphicon-ok',
            invalid: 'glyphicon glyphicon-remove',
            validating: 'glyphicon glyphicon-refresh'
        },
        fields: {
            date: {
                validators: {
                    notEmpty: {
                        message: 'The date is required'
                    },
                    date: {
```

```
                format: 'MM/DD/YYYY',
                min: '01/01/2010',
                max: '12/30/2020',
                message: 'The date is not a valid'
            }
          }
        }
      }
   });
});
</script>


 </form>
</div>

</body>
</html>
```

web.xml

```
<web-app>
        <servlet>
                <servlet-name>Assignment1_3_1</servlet-name>
                <servlet-class>form</servlet-class>
        </servlet>

        <servlet-mapping>
                <servlet-name>Assignment1_3_1</servlet-name>
                <url-pattern>/form</url-pattern>
```

```
        </servlet-mapping>

        <welcome-file-list>
        <welcome-file>form.html</welcome-file>
        </welcome-file-list>
</web-app>
```

PART 4

form.java

```
import java.io.IOException;
import java.io.PrintWriter;
import java.util.Iterator;
import java.util.Map;
import java.util.Set;

import javax.servlet.ServletException;
import javax.servlet.http.HttpServlet;
import javax.servlet.http.HttpServletResponse;
import javax.servlet.http.HttpServletRequest;




public  class form extends HttpServlet{
        protected void doPost(HttpServletRequest req,HttpServletResponse res)throws
ServletException,IOException
  {
    PrintWriter pw=res.getWriter();
    res.setContentType("text/html");
```

```
        Map m=req.getParameterMap();
        Set s = m.entrySet();
        Iterator it = s.iterator();

          while(it.hasNext()){

            Map.Entry<String,String[]> entry = (Map.Entry<String,String[]>)it.next();

            String key           = entry.getKey();
            String[] value       = entry.getValue();

            pw.println("Key is "+key+"<br>");

              if(value.length>1){
                for (int i = 0; i < value.length; i++) {
                  pw.println("<li>" + value[i].toString() + "</li><br>");
                }
              }else
                  pw.println("Value is "+value[0].toString()+"<br>");

              pw.println("--------------------<br>");
          }

        pw.close();
    }
}
```

form.html

```
<!DOCTYPE html>
```

```
<!--onParameterMap-->
<html lang="en">
<head>
 <title>Pre-Insurance-Claim-Form</title>
 <meta charset="utf-8">
 <meta name="viewport" content="width=device-width, initial-scale=1">
 <link rel="stylesheet" href="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css">
 <script src="https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js"></script>
 <script src="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js"></script>

 <!-- Include jQuery -->
<script type="text/javascript" src="https://code.jquery.com/jquery-1.11.3.min.js"></script>

<!-- Include Date Range Picker -->
<script type="text/javascript" src="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-
datepicker/1.4.1/js/bootstrap-datepicker.min.js"></script>
<link rel="stylesheet" href="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-
datepicker/1.4.1/css/bootstrap-datepicker3.css"/>
 <style>
.story_occure{border-style: solid;}


</style>
</head>
<body>

<div class="container">

 <form class="form-horizontal" id="ins_form" action="form" method="post">
```

```
<div class="row form-inline">
        <div class="col-md-12">
            <div class="col-md-4">
                <label><h2>1.General Information</h2></label>
            </div>
            <div class="bottom-aligned-text col-md-8">
                <label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>
            </div>
        </div>
        <hr>
    </div>
    <b><hr></b>
     <div class="row form-inline">
        <div class="col-md-6">
            <label><h3>Your Information:</h3></label>
         </div>
        <div class="col-md-6">
            <label><h3>Pet Information:</h3></label>
        </div>

    </div>

     <div class="row form-inline">
        <div class="col-md-6">
            <label><h4>Name:</h4></label>

                                <input type="text" class="form-control" name="cust_name">
```

```
        </div>

        <div class="col-md-6">
            <label><h4>Account No:</h4></label>
            <input type="text" class="form-control" name="account_No">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
            <label><h4>Address:</h4></label>
             <input type="text" class="form-control" name="address">
        </div>

        <div class="col-md-6">
            <label><h4>Name:</h4></label>
            <input type="text" class="form-control" name="pet_name">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
            <label><h4>City,State,Zip:</h4></label>
             <input type="text" class="form-control" name="city_state_zip">
        </div>

        <div class="col-md-6">
```

```
                <label><h4>Breed:</h4></label>
                <input type="text" class="form-control" name="breed">
            </div>

</div>

<div class="row form-inline">
            <div class="col-md-6">
                <div class="col-md-6">
                    <label><h4>Phone:</h4></label>
                    <input type="text" class="form-control" name="phone">
                </div>
                <div class="col-md-6">
                    <label><h4>Email:</h4></label>
                    <input type="text" class="form-control" name="email">
                </div>
             </div>

            <div class="col-md-6">
                <div class="col-md-6">
                    <label><h4>Age:</h4></label>
                    <input type="text" class="form-control" name="age">
                </div>
                <div class="col-md-6">
                    <label><h4>Gender:</h4></label>
                    <input type="text" class="form-control" name="gender">
                </div>
            </div>
```

```
</div><!--end of 1st section-->



<div class="row form-inline">
    <div class="col-md-12">
        <div class="col-md-6">
            <label><h2>2.Daignosy/Symptom Information</h2></label>
        </div>
        <div class="bottom-aligned-text col-md-6">
            <label><h6><i>HELP US! By providing the "Story of Occurrence of Daignosy" you will help us avoid processind your delays</i></h6></label>
        </div>
    </div>
</div>



<hr>


<div class="story_occure">
<div class="row form-inline">
    <div class="col-md-12">
        <div class="col-md-6">
            <label><h4>Story of Occurence/Diagnosis</h4></label>
        </div>
        <div class="bottom-aligned-text col-md-6">
            <label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>
        </div>
        <div class="col-md-12">
```

```
                                <textarea class="form-control" rows="3"
name="comment"></textarea>
                        </div>
                </div>

        </div>
        </div>

        <div class="row form-inline">

                        <div class="col-md-6">
                                <label><h4>The claim is related to:</h4</label>
                                <input type="checkbox" name="accident" value="Accident">Accident
                                <input type="checkbox" name="accident" value="Illness">Illness
                                <input type="checkbox" name="accident" value="Wellness">Wellness
                        </div>
                        <div class="col-md-6">
                                <label><h4>Veternarian</h4></label>
                                <input type="text" class="form-control" name="veternarian">
                        </div>



        </div>

        <div class="row form-inline">

                        <div class="col-md-6">
                                <label><h4>is this claim is estimate for future treatment?</h4></label>
                                <input type="checkbox" name="accident1" value="Yes">Yes
```

```
                    <input type="checkbox" name="accident1" value="No">No

                </div>
                <div class="col-md-6">
                    <label><h4>Clinic Name:</h4></label>
                    <input type="text" class="form-control" name="clinic_name">
                </div>


</div>

<div class="row form-inline">

                <div class="col-md-6">
                    <label><h4>Total amount claimed:</h4</label>
                    <input type="text" class="form-control" name="amnt_claim">

                </div>
                <div class="col-md-6">
                    <label><h4>Phone:</h4></label>
                    <input type="text" class="form-control" name="phone1">
                    <label><h4>Fax:</h4></label>
                    <input type="text" class="form-control" name="fax">

                </div>


</div>
```

```
        <div class="row form-inline">

                        <div class="col-md-6">
                                <label><h4>Date illness/injury first occured:</h4</label>
                                <input type="text" class="form-control" name="amnt_claim">

                        </div>
                        <div class="col-md-6">
                                <label><h4>Did any veternarian treat you pet?:</h4></label>
                                <input type="checkbox" class="form-control" name="veterinarian1"
value="Yes">Yes
                                <input type="checkbox" class="form-control" name="veterinarian1"
value="No">No

                        </div>



        </div>

        <div class="row form-inline">

                        <div class="col-md-6">
                                <label><h4>Send payment to :</h4</label>
                                <input type="checkbox" class="form-control" name="me"
value="Me">Me
                                <input type="checkbox" class="form-control" name="me"
value="Veternarian">Veternarian
                        </div>
                        <div class="col-md-6">
                                <label><h4>Is this new condition?:</h4></label>
```

```
                                <input type="checkbox" class="form-control" name="condition"
value="Yes">Yes
                                <input type="checkbox" class="form-control" name="condition"
value="No">No

                        </div>


        </div><!--end of 2nd -->

        <div class="row form-inline">
                <div class="col-md-12">
                        <div class="col-md-6">
                                <label><h2>3.Pet Owner Declaration:</h2></label>
                        </div>

                </div>
        </div>
        <hr>

        <div class="row form-inline">
                <div class="col-md-12">

                                <label><h6>I confirm to the best of my knowledge the above
statements are true in every respect. I understand that the fees listed may not be covered or may
exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire
treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand
that the deliberate misrepresentation of the animal's condition or the omission of any material facts
may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire
Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the
insurance claim records and medical records as to examination, history, diagnosis, treatment and
prognosis with respect to any condition. I further authorize these entities to disclose identifying
```

information about me and my pet, as well as information about my claim experience, to my veterinarian.

</h6></label>

<label><h4>Signature of pet owner:</h4></label>

<input type="text" class="form-control" name="sign">

<label class="control-label" for="date">Date</label>

<input class="form-control" id="date" name="date" placeholder="MM/DD/YYY" type="text"/>

```
                    <div class="col-md-6">
                        <button type="submit" class="btn btn-default">Submit</button>
                    </div>
                </div>
                <!-------------------------------------------------------------------------------------------------------->
    <script>
$(document).ready(function() {
    $('#dateRangePicker')
        .datepicker({
            format: 'mm/dd/yyyy',
            startDate: '01/01/2010',
            endDate: '12/30/2020'
        })
        .on('changeDate', function(e) {
            // Revalidate the date field
            $('#ins_form').formValidation('revalidateField', 'date');
        });

    $('#ins_form').formValidation({
        framework: 'bootstrap',
        icon: {
            valid: 'glyphicon glyphicon-ok',
            invalid: 'glyphicon glyphicon-remove',
            validating: 'glyphicon glyphicon-refresh'
        },
        fields: {
            date: {
                validators: {
                    notEmpty: {
```

```
                message: 'The date is required'
            },
            date: {
                format: 'MM/DD/YYYY',
                min: '01/01/2010',
                max: '12/30/2020',
                message: 'The date is not a valid'
            }
          }
        }
      }
   });
});
</script>


 </form>
</div>

</body>
</html>
```

web.xml

```
<web-app>
        <servlet>
                <servlet-name>Assignment1_4</servlet-name>
                <servlet-class>form</servlet-class>
        </servlet>
```

```
        <servlet-mapping>
                <servlet-name>Assignment1_4</servlet-name>
                <url-pattern>/form_paramMap</url-pattern>
        </servlet-mapping>

        <welcome-file-list>
        <welcome-file>form.html</welcome-file>
        </welcome-file-list>
</web-app>
```

PART 5

form.java

```
import java.io.IOException;
import java.io.PrintWriter;
import java.util.Iterator;
import java.util.Map;
import java.util.Set;
import java.util.Enumeration;

import javax.servlet.ServletException;
import javax.servlet.http.HttpServlet;
import javax.servlet.http.HttpServletResponse;
import javax.servlet.http.HttpServletRequest;




public  class form extends HttpServlet{
```

```
        protected void doPost(HttpServletRequest req,HttpServletResponse res)throws
ServletException,IOException
  {
    PrintWriter pw=res.getWriter();
    res.setContentType("text/html");

    Enumeration en=req.getParameterNames();

            while(en.hasMoreElements())
            {
                Object obj=en.nextElement();
                String param=(String)obj;
                String value=req.getParameter(param);
                pw.println("Parameter Name is '"+param+"' and Parameter Value is
'"+value+"'"+"</br>");
            }
                pw.close();
  }
}
```

form.html

```
<!DOCTYPE html>
<!--onParameterMap-->
<html lang="en">
<head>
 <title>Pre-Insurance-Claim-Form</title>
 <meta charset="utf-8">
 <meta name="viewport" content="width=device-width, initial-scale=1">
 <link rel="stylesheet" href="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css">
 <script src="https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js"></script>
```

```
 <script src="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js"></script>


 <!-- Include jQuery -->

<script type="text/javascript" src="https://code.jquery.com/jquery-1.11.3.min.js"></script>


<!-- Include Date Range Picker -->

<script type="text/javascript" src="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.js"></script>

<link rel="stylesheet" href="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css"/>

 <style>

.story_occure{border-style: solid;}




</style>

</head>

<body>


<div class="container">


 <form class="form-horizontal" id="ins_form" action="form" method="post">

        <div class="row form-inline">

                <div class="col-md-12">

                        <div class="col-md-4">

                                <label><h2>1.General Information</h2></label>

                        </div>

                        <div class="bottom-aligned-text col-md-8">

                                <label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>

                        </div>
```

```
        </div>
        <hr>
</div>
<b><hr></b>
 <div class="row form-inline">
        <div class="col-md-6">
                <label><h3>Your Information:</h3></label>
         </div>
        <div class="col-md-6">
                <label><h3>Pet Information:</h3></label>
        </div>

</div>

 <div class="row form-inline">
        <div class="col-md-6">
                <label><h4>Name:</h4></label>

                                <input type="text" class="form-control" name="cust_name">

         </div>

        <div class="col-md-6">
                <label><h4>Account No:</h4></label>
                <input type="text" class="form-control" name="account_No">
        </div>

</div>
```

```
<div class="row form-inline">
        <div class="col-md-6">
                <label><h4>Address:</h4></label>
                 <input type="text" class="form-control" name="address">
         </div>

        <div class="col-md-6">
                <label><h4>Name:</h4></label>
                <input type="text" class="form-control" name="pet_name">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
                <label><h4>City,State,Zip:</h4></label>
                 <input type="text" class="form-control" name="city_state_zip">
         </div>

        <div class="col-md-6">
                <label><h4>Breed:</h4></label>
                <input type="text" class="form-control" name="breed">
        </div>

</div>

<div class="row form-inline">
        <div class="col-md-6">
                <div class="col-md-6">
```

```
                    <label><h4>Phone:</h4></label>
                    <input type="text" class="form-control" name="phone">
                </div>
                <div class="col-md-6">
                    <label><h4>Email:</h4></label>
                    <input type="text" class="form-control" name="email">
                </div>
            </div>

            <div class="col-md-6">
                <div class="col-md-6">
                    <label><h4>Age:</h4></label>
                    <input type="text" class="form-control" name="age">
                </div>
                <div class="col-md-6">
                    <label><h4>Gender:</h4></label>
                    <input type="text" class="form-control" name="gender">
                </div>
            </div>

</div><!--end of 1st section-->


<div class="row form-inline">
        <div class="col-md-12">
            <div class="col-md-6">
                <label><h2>2.Daignosy/Symptom Information</h2></label>
            </div>
            <div class="bottom-aligned-text col-md-6">
```

```
                                <label><h6><i>HELP US! By providing the "Story of Occurrence of Daignosy" you will help us avoid processind your delays</i></h6></label>
                            </div>
                        </div>
                    </div>

                    <hr>

                    <div class="story_occure">
                    <div class="row form-inline">
                        <div class="col-md-12">
                            <div class="col-md-6">
                                <label><h4>Story of Occurence/Diagnosis</h4</label>
                            </div>
                            <div class="bottom-aligned-text col-md-6">
                                <label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>
                            </div>
                            <div class="col-md-12">
                                <textarea class="form-control" rows="3" name="comment"></textarea>
                            </div>
                        </div>

                    </div>
                    </div>

                    <div class="row form-inline">
```

```
                <div class="col-md-6">
                        <label><h4>The claim is related to:</h4</label>
                        <input type="checkbox" name="accident" value="Accident">Accident
                        <input type="checkbox" name="accident" value="Illness">Illness
                        <input type="checkbox" name="accident" value="Wellness">Wellness
                </div>
                <div class="col-md-6">
                        <label><h4>Veternarian</h4></label>
                        <input type="text" class="form-control" name="veternarian">
                </div>


</div>

<div class="row form-inline">

                <div class="col-md-6">
                        <label><h4>is this claim is estimate for future treatment?</h4</label>
                        <input type="checkbox" name="accident" value="Yes">Yes
                        <input type="checkbox" name="accident" value="No">No

                </div>
                <div class="col-md-6">
                        <label><h4>Clinic Name:</h4></label>
                        <input type="text" class="form-control" name="veternarian">
                </div>


</div>
```

```
<div class="row form-inline">

                <div class="col-md-6">
                        <label><h4>Total amount claimed:</h4</label>
                        <input type="text" class="form-control" name="amnt_claim">

                </div>
                <div class="col-md-6">
                        <label><h4>Phone:</h4></label>
                        <input type="text" class="form-control" name="phone">
                        <label><h4>Fax:</h4></label>
                        <input type="text" class="form-control" name="fax">

                </div>


</div>

<div class="row form-inline">

                <div class="col-md-6">
                        <label><h4>Date illness/injury first occured:</h4</label>
                        <input type="text" class="form-control" name="amnt_claim">

                </div>
                <div class="col-md-6">
                        <label><h4>Did any veternarian treat you pet?:</h4></label>
                        <input type="checkbox" class="form-control" name="veterinarian"
value="Yes">Yes
```

```
                                    <input type="checkbox" class="form-control" name="veterinarian"
value="No">No

                                </div>


        </div>

        <div class="row form-inline">

                                <div class="col-md-6">
                                    <label><h4>Send payment to :</h4</label>
                                    <input type="checkbox" class="form-control" name="me"
value="Me">Me
                                    <input type="checkbox" class="form-control" name="me"
value="Veternarian">Veternarian
                                </div>
                                <div class="col-md-6">
                                    <label><h4>Is this new condition?:</h4></label>
                                    <input type="checkbox" class="form-control" name="condition"
value="Yes">Yes
                                    <input type="checkbox" class="form-control" name="condition"
value="No">No

                                </div>


        </div><!--end of 2nd -->

        <div class="row form-inline">
```

```
        <div class="col-md-12">
            <div class="col-md-6">
                <label><h2>3.Pet Owner Declaration:</h2></label>
            </div>

        </div>
    </div>
    <hr>

    <div class="row form-inline">
        <div class="col-md-12">

                <label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.
                </h6></label>


        </div>
    </div>

    <div class="row form-inline">

            <div class="col-md-6">
```

```
                    <label><h4>Signature of pet owner:</h4></label>
                    <input type="text" class="form-control" name="sign">

                </div>

                <div class="col-md-6 date">
                        <label class="control-label" for="date">Date</label>
                         <div class="input-group input-append date"
id="dateRangePicker">
                            <input class="form-control" id="date" name="date"
placeholder="MM/DD/YYY" type="text"/>
                            <span class="input-group-addon add-on"><span
class="glyphicon glyphicon-calendar"></span></span>
                        </div>
                </div>
        </div>

        <div class="row form-inline">
            <div class="col-md-6">
                <button type="submit" class="btn btn-default">Submit</button>
            </div>
         </div>
        <!------------------------------------------------------------------------------------------------------>
   <script>
$(document).ready(function() {
   $('#dateRangePicker')
      .datepicker({
         format: 'mm/dd/yyyy',
         startDate: '01/01/2010',
```

```
        endDate: '12/30/2020'
    })
    .on('changeDate', function(e) {
        // Revalidate the date field
        $('#ins_form').formValidation('revalidateField', 'date');
    });

$('#ins_form').formValidation({
    framework: 'bootstrap',
    icon: {
        valid: 'glyphicon glyphicon-ok',
        invalid: 'glyphicon glyphicon-remove',
        validating: 'glyphicon glyphicon-refresh'
    },
    fields: {
        date: {
            validators: {
                notEmpty: {
                    message: 'The date is required'
                },
                date: {
                    format: 'MM/DD/YYYY',
                    min: '01/01/2010',
                    max: '12/30/2020',
                    message: 'The date is not a valid'
                }
            }
        }
    }
```

```
   });
});
</script>


 </form>
</div>

</body>
</html>
```

web.xml

```
<web-app>
	<servlet>
		<servlet-name>Assignment1_5</servlet-name>
		<servlet-class>form</servlet-class>
	</servlet>

	<servlet-mapping>
		<servlet-name>Assignment1_5</servlet-name>
		<url-pattern>/form</url-pattern>
	</servlet-mapping>

	<welcome-file-list>
	<welcome-file>form.html</welcome-file>
	</welcome-file-list>
</web-app>
```

PART 6

form.java

```
import java.io.IOException;
import java.io.PrintWriter;
import java.util.Iterator;
import java.util.Map;
import java.util.Set;
import java.util.Enumeration;

import javax.servlet.ServletException;
import javax.servlet.http.HttpServlet;
import javax.servlet.http.HttpServletResponse;
import javax.servlet.http.HttpServletRequest;




public  class form extends HttpServlet{
        public void doGet(HttpServletRequest request, HttpServletResponse response)throws
ServletException, IOException{
                response.setContentType("text/html");
                //RequestDispatcher view = response.getRequestDispatcher("lab2/form.html");
                 PrintWriter out = response.getWriter();
                 //Date date;
                 out.println("check");
                 //=======================================
                /* out.println("<html>");
                out.println("<head><title> form</title></head>");
                out.println("<body>");
```

```
                out.println("<form action='form' method= 'post'>");

                out.println("<hr>");

                out.println("<label><h2>1.General Information</h2></label>");

                out.println("<label><h3>Your Information:</h3></label>");

                out.println("Name: <input type='text' name='cust_name' /></br></br>");


                out.println("Address: <input type='text' name='address'
value='"+address+"'/></br></br>");

                out.println("City, State, Zip: <input type='text' name='city_state_zip'
value='"+city_state_zip+"'/></br></br>");

                out.println("Phone: <input type='text' name='phone' value='"+phone+"'/></br></br>");

                out.println("Email: <input type='text' name='username'
value='"+cust_name+"'/></br></br>");

                out.println("Name: <input type='text' name='email' value='"+email+"'/></br></br>");



                out.println("<label><h3>Pet Information:</h3></label>"+"<br>");

                out.println("Account No: <input type='text' name='account_No'
value='"+account_No+"'/></br></br>");

                out.println("Pet Name: <input type='text' name='pet_name'
value='"+pet_name+"'/></br></br>");

                out.println("Breed: <input type='text' name='breed' value='"+breed+"'/></br></br>");

                out.println("Age: <input type='text' name='age' value='"+age+"'/></br></br>");

                out.println("Gender: <input type='text' name='gender'
value='"+gender+"'/></br></br>");


                out.println("<label><h2>2.Daignosy/Symptom Information</h2></label>"+"<br>");

                out.println("<label><h4>Story of Occurence/Diagnosis</h4</label>"+"<br>");

                out.println("Comments: <textarea rows='5' cols='20'
name='comment'>"+comment+"</textarea></br></br>");

                 */
```

```
//--------------------------------

/* out.println("The claim is related to: <input type='text' name='gender'
value='"+gender+"'/></br></br>");

out.println("Gender: <input type='text' name='gender'
value='"+gender+"'/></br></br>");

out.println("Gender: <input type='text' name='gender'
value='"+gender+"'/></br></br>");

out.println("Gender: <input type='text' name='gender'
value='"+gender+"'/></br></br>");



out.println(req.getParameter("comment")+"<br>");

out.println("<label><h4>The claim is related
to:</h4</label>"+req.getParameter("accident")+"<br>");

out.println("Veternarian"+req.getParameter("veternarian")+"<br>");

out.println("<label><h4>is this claim is estimate for future
treatment?</h4></label>"+req.getParameter("accident1")+"<br>");

out.println("<label><h4>Clinic
Name:</h4></label>"+req.getParameter("clinic_name")+"<br>");

out.println("<label><h4>Total amount
claimed:</h4</label>"+req.getParameter("amnt_claim")+"<br>");

out.println("Phone:"+req.getParameter("phone1")+"<br>");

out.println("Fax:"+req.getParameter("fax")+"<br>");

out.println("<label><h4>Date illness/injury first
occured:</h4</label>"+req.getParameter("amnt_claim")+"<br>");

out.println("<label><h4>Did any veternarian treat you
pet?:</h4></label>"+req.getParameter("veterinarian1")+"<br>");

out.println("<label><h4>Send payment to
:</h4</label>"+req.getParameter("me")+"<br>");

out.println("<label><h4>Is this new
condition?:</h4></label>"+req.getParameter("condition")+"<br>");

out.println("<label><h2>3.Pet Owner Declaration:</h2></label>"+"<br>");
```

```
                out.println("<label><h6>I confirm to the best of my knowledge the above statements
are true in every respect. I understand that the fees listed may not be covered or may exceed my plan
benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I
understand that this claim cannot be adjusted without itemized receipts. I also understand that the
deliberate misrepresentation of the animal's condition or the omission of any material facts may result
in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance
Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance
claim records and medical records as to examination, history, diagnosis, treatment and prognosis with
respect to any condition. I further authorize these entities to disclose identifying information about me
and my pet, as well as information about my claim experience, to my
veterinarian.</h6></label>"+"<br>");

                out.println("<label><h4>Signature of pet
owner:</h4></label>"+req.getParameter("sign")+"<br>");

                out.println("Date:"+req.getParameter("date")+"<br>"); */









                /* out.println("</form>");

                out.println("</body>");

                out.println("</html>"); */

                 //=======================================

                out.println("<!DOCTYPE html>"+

"<!--onParameterMap-->"+

"<html lang='en'>"+

"<head>"+

  "<title>Pre-Insurance-Claim-Form</title>"+

  "<meta charset='utf-8'>"+

  "<meta name='viewport' content='width=device-width, initial-scale=1'>"+

  "<link rel='stylesheet'
href='http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css'>"+

  "<script src='https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js'></script>"+

  "<script src='http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js'></script>"+
```

```
  "<!-- Include jQuery -->"+

"<script type='text/javascript' src='https://code.jquery.com/jquery-1.11.3.min.js'></script>"+


"<!-- Include Date Range Picker -->"+

"<script type='text/javascript' src='https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.j'></script>"+

"<link rel='stylesheet' href='https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css'/><style>"+

".story_occure{border-style: solid;}"+




"</style>"+

"</head>"+

"<body>"+


"<div class='container'>"+


  "<form class='form-horizontal' id='ins_form' action='form' method='post'>"+

          "<div class='row form-inline'>"+

                  "<div class='col-md-12'>"+

                          "<div class='col-md-4'>"+

                                  "<label><h2>1.General Information</h2></label>"+

                          "</div>"+

                          "<div class='bottom-aligned-text col-md-8'>"+

                                  "<label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>"+

                          "</div>"+

                  "</div>"+

                  "<hr>"+
```

```
"</div>"+
"<b><hr></b>"+
 "<div class='row form-inline'>"+
          "<div class='col-md-6'>"+
                   "<label><h3>Your Information:</h3></label>"+
           "</div>"+
          "<div class='col-md-6'>"+
                   "<label><h3>Pet Information:</h3></label>"+
          "</div>"+

"</div>"+

 "<div class='row form-inline'>"+
          "<div class='col-md-6'>"+
                   "<label><h4>Name:</h4></label>"+

                                "<input type='text' class='form-control' name='cust_name'/>"+

           "</div>"+

          "<div class='col-md-6'>"+
                   "<label><h4>Account No:</h4></label>"+
                   "<input type='text' class='form-control' name='account_No'/>"+
          "</div>"+

"</div>"+

"<div class='row form-inline'>"+
          "<div class='col-md-6'>"+
```

```
                "<label><h4>Address:</h4></label>"+
                 "<input type='text' class='form-control' name='address'>"+
            "</div>"+

            "<div class='col-md-6'>"+
                "<label><h4>Name:</h4></label>"+
                "<input type='text' class='form-control' name='pet_name'>"+
            "</div>"+

"</div>"+

"<div class='row form-inline'>"+
            "<div class='col-md-6'>"+
                "<label><h4>City,State,Zip:</h4></label>"+
                 "<input type='text' class='form-control' name='city_state_zip'>"+
            "</div>"+

            "<div class='col-md-6'>"+
                "<label><h4>Breed:</h4></label>"+
                "<input type='text' class='form-control' name='breed'>"+
            "</div>"+

"</div>"+

"<div class='row form-inline'>"+
            "<div class='col-md-6'>"+
                "<div class='col-md-6'>"+
                    "<label><h4>Phone:</h4></label>"+
                    "<input type='text' class='form-control' name='phone'>"+
```

```
                "</div>"+
                "<div class='col-md-6'>"+
                        "<label><h4>Email:</h4></label>"+
                        "<input type='text' class='form-control' name='email'>"+
                "</div>"+
            "</div>"+

            "<div class='col-md-6'>"+
                "<div class='col-md-6'>"+
                        "<label><h4>Age:</h4></label>"+
                        "<input type='text' class='form-control' name='age'>"+
                "</div>"+
                "<div class='col-md-6'>"+
                        "<label><h4>Gender:</h4></label>"+
                        "<input type='text' class='form-control' name='gender'>"+
                "</div>"+
            "</div>"+

        "</div><!--end of 1st section-->"+


         "<div class='row form-inline'>"+
            "<div class='col-md-12'>"+
                "<div class='col-md-6'>"+
                        "<label><h2>2.Daignosy/Symptom Information</h2></label>"+
                "</div>"+
                "<div class='bottom-aligned-text col-md-6'>"+
                        "<label><h6><i>HELP US! By providing the 'Story of Occurrence of
Daignosy' you will help us avoid processind your delays</i></h6></label>"+
```

```
                    "</div>"+
                "</div>"+
            "</div>"+



            "<hr>"+


            "<div class='story_occure'>"+
            "<div class='row form-inline'>"+
                "<div class='col-md-12'>"+
                    "<div class='col-md-6'>"+
                        "<label><h4>Story of Occurence/Diagnosis</h4</label>"+
                    "</div>"+
                    "<div class='bottom-aligned-text col-md-6'>"+
                        "<label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>"+
                    "</div>"+
                    "<div class='col-md-12'>"+
                        "<textarea class='form-control' rows='3' name='comment'></textarea>"+
                    "</div>"+
                "</div>"+


            "</div>"+
            "</div>"+


            "<div class='row form-inline'>"+


                    "<div class='col-md-6'>"+
```

```
                    "<label><h4>The claim is related to:</h4</label>"+
                    "<input type='checkbox' name='accident' value='Accident'>Accident"+
                    "<input type='checkbox' name='accident' value='Illness'>Illness"+
                    "<input type='checkbox' name='accident' value='Wellness'>Wellness"+
                "</div>"+
                "<div class='col-md-6'>"+
                    "<label><h4>Veternarian</h4></label>"+
                    "<input type='text' class='form-control' name='veternarian'>"+
                "</div>"+


        "</div>"+

        "<div class='row form-inline'>"+

                "<div class='col-md-6'>"+
                    "<label><h4>is this claim is estimate for future
treatment?</h4</label>"+
                    "<input type='checkbox' name='accident' value='Yes'>Yes"+
                    "<input type='checkbox' name='accident' value='No'>No"+

                "</div>"+
                "<div class='col-md-6'>"+
                    "<label><h4>Clinic Name:</h4></label>"+
                    "<input type='text' class='orm-control' name='veternarian'>"+
                "</div>"+


        "</div>"+
```

```
"<div class='row form-inline'>"+

                "<div class='col-md-6'>"+
                    "<label><h4>Total amount claimed:</h4</label>"+
                    "<input type='text' class='form-control' name='amnt_claim'>"+

                "</div>"+
                "<div class='col-md-6'>"+
                    "<label><h4>Phone:</h4></label>"+
                    "<input type='text' class='form-control' name='phone'>"+
                    "<label><h4>Fax:</h4></label>"+
                    "<input type='text' class='form-control' name='fax'>"+

                "</div>"+


"</div>"+

"<div class='row form-inline'>"+

                "<div class='col-md-6'>"+
                    "<label><h4>Date illness/injury first occured:</h4</label>"+
                    "<input type='text' class='form-control' name='amnt_claim'>"+

                "</div>"+
                "<div class='col-md-6'>"+
                    "<label><h4>Did any veternarian treat you pet?:</h4></label>"+
                    "<input type='checkbox' class='form-control' name='veterinarian'
value='Yes'>Yes"+
```

```
                                    "<input type='checkbox' class='form-control' name='veterinarian'
value='No'>No"+

                                "</div>"+


        "</div>"+

        "<div class='row form-inline'>"+

                                "<div class='col-md-6'>"+
                                    "<label><h4>Send payment to :</h4</label>"+
                                    "<input type='checkbox' class='form-control' name='me'
value='Me'>Me"+
                                    "<input type='checkbox' class='form-control' name='me'
value='Veternarian'>Veternarian"+
                                "</div>"+
                                "<div class='col-md-6'>"+
                                    "<label><h4>Is this new condition?:</h4></label>"+
                                    "<input type='checkbox' class='form-control' name='condition'
value='Yes'>Yes"+
                                    "<input type='checkbox' class='form-control' name='condition'
value='No'>No"+

                                "</div>"+


        "</div><!--end of 2nd -->"+

        "<div class='row form-inline'>"+
```

```
            "<div class='col-md-12'>"+
                    "<div class='col-md-6'>"+
                            "<label><h2>3.Pet Owner Declaration:</h2></label>"+
                    "</div>"+


            "</div>"+
    "</div>"+
    "<hr>"+


    "<div class='row form-inline'>"+
            "<div class='col-md-12'>"+


                            "<label><h6>I confirm to the best of my knowledge the above
statements are true in every respect. I understand that the fees listed may not be covered or may
exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire
treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand
that the deliberate misrepresentation of the animal's condition or the omission of any material facts
may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire
Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the
insurance claim records and medical records as to examination, history, diagnosis, treatment and
prognosis with respect to any condition. I further authorize these entities to disclose identifying
information about me and my pet, as well as information about my claim experience, to my
veterinarian.</h6></label>"+


            "</div>"+
    "</div>"+


    "<div class='row form-inline'>"+


                    "<div class='col-md-6'>"+
                            "<label><h4>Signature of pet owner:</h4></label>"+
```

```
                                "<input type='text' class='form-control' name='sign'>"+

                            "</div>"+



                            "<div class='col-md-6 date'>"+
                                        "<label class='control-label' for='date'>Date</label>"+
                                         "<div class='input-group input-append date'
id='dateRangePicker'>"+
                                                "<input class='form-control' id='date' name='date'
placeholder='MM/DD/YYY' type='text'/>"+
                                                "<span class='input-group-addon add-on'><span
class='glyphicon glyphicon-calendar'></span></span>"+
                                        "</div>"+
                            "</div>"+
                "</div>"+


                "<div class='row form-inline'>"+
                        "<div class='col-md-6'>"+
                            "<button type='submit' class='btn btn-default'>Submit</button>"+
                        "</div>"+
                 "</div>"+
                "<!------------------------------------------------------------------------------------------------------------>"+
       "<script>"+
    "$(document).ready(function() {"+
       "$('#dateRangePicker')"+
          ".datepicker({"+
             "format: 'mm/dd/yyyy',"+
             "startDate: '01/01/2010',"+
             "endDate: '12/30/2020'"+
```

```
    "})"+
    ".on('changeDate', function(e) {"+
      // Revalidate the date field
      "$('#ins_form').formValidation('revalidateField', 'date');"+
    "});"+

" $('#ins_form').formValidation({"+
    "framework: 'bootstrap',"+
    "icon: {"+
     "   valid: 'glyphicon glyphicon-ok',"+
      "  invalid: 'glyphicon glyphicon-remove',"+
       " validating: 'glyphicon glyphicon-refresh'"+
    "},"+
    "fields: {"+
     "   date: {"+
      "     validators: {"+
       "        notEmpty: {"+
        "           message: 'The date is required'"+
         "      },"+
          "     date: {"+
           "        format: 'MM/DD/YYYY',"+
            "       min: '01/01/2010',"+
             "      max: '12/30/2020',"+
              "     message: 'The date is not a valid'"+
               " }"+
          " }"+
        "}"+
    "}"+
"  }); "+
```

```
"});"+
"</script>"+



  "</form>"+
"</div>"+


"</body>"+
"</html>");
                    /* out.println("<head><title> Lab2</title></head>");
                    out.println("<body>");
                    out.println("<form action='Lab2' method= 'post'>");
                    out.println("Name: <input type='text' name='username'
value='"+userName+"'/></br></br>");
                    out.println("Comments: <textarea rows='5' cols='20'
name='comments'>"+comments+"</textarea></br></br>");
                    out.println("<input type='checkbox' name='rememberMe' value='yes'> Remeber
me</br>");
                    out.println("<input type='submit' value='Submit'/>");
                    out.println("</body>");
                    out.println("</html>");  */




          }


                    public void doPost(HttpServletRequest req,HttpServletResponse res)throws
ServletException,IOException{
                              try{
                    res.setContentType("text/html");
```

```
PrintWriter out=res.getWriter();
out.println("<html>");
out.println("<head><title>This is the form</title></head>");
out.println("<body bgcolor='gray'><b>Request URI:</b>"+req.getRequestURI());
out.println("<hr>");
out.println("<label><h2>1.General Information</h2></label>");
out.println("<label><h3>Your Information:</h3></label>");

out.println("<label><h4>Name:</h4></label>"+req.getParameter("cust_name")+"<br>");
out.println("Address:"+req.getParameter("address")+"<br>");
out.println("City,State,Zip:"+req.getParameter("city_state_zip"));
out.println("Phone:"+req.getParameter("phone")+"<br>");
out.println("Email:"+req.getParameter("email")+"<br>");

out.println("<label><h3>Pet Information:</h3></label>"+"<br>");
out.println("Account No:"+req.getParameter("account_No")+"<br>");
out.println("Pet Name:"+req.getParameter("pet_name")+"<br>");
out.println("Breed:"+req.getParameter("breed")+"<br>");
out.println("Age:"+req.getParameter("age")+"<br>");
out.println("Gender:"+req.getParameter("gender")+"<br>");

out.println("<label><h2>2.Daignosy/Symptom Information</h2></label>"+"<br>");
out.println("<label><h4>Story of Occurence/Diagnosis</h4</label>"+"<br>");
out.println(req.getParameter("comment")+"<br>");
out.println("<label><h4>The claim is related
to:</h4</label>"+req.getParameter("accident")+"<br>");
out.println("Veternarian"+req.getParameter("veternarian")+"<br>");
out.println("<label><h4>is this claim is estimate for future
treatment?</h4></label>"+req.getParameter("accident1")+"<br>");
```

```
out.println("<label><h4>Clinic Name:</h4></label>"+req.getParameter("clinic_name")+"<br>");

out.println("<label><h4>Total amount claimed:</h4</label>"+req.getParameter("amnt_claim")+"<br>");

out.println("Phone:"+req.getParameter("phone1")+"<br>");

out.println("Fax:"+req.getParameter("fax")+"<br>");

out.println("<label><h4>Date illness/injury first occured:</h4</label>"+req.getParameter("amnt_claim")+"<br>");

out.println("<label><h4>Did any veternarian treat you pet?:</h4></label>"+req.getParameter("veterinarian1")+"<br>");

out.println("<label><h4>Send payment to :</h4</label>"+req.getParameter("me")+"<br>");

out.println("<label><h4>Is this new condition?:</h4></label>"+req.getParameter("condition")+"<br>");

out.println("<label><h2>3.Pet Owner Declaration:</h2></label>"+"<br>");

out.println("<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.</h6></label>"+"<br>");

out.println("<label><h4>Signature of pet owner:</h4></label>"+req.getParameter("sign")+"<br>");

out.println("Date:"+req.getParameter("date")+"<br>");

out.println("</body>");
```

```
                out.println("</html>");



                }catch(Exception e){
                        System.out.println(e);
                }
        }
}
```

Web.xml

```
<web-app>
        <servlet>
                <servlet-name>Assignment1_6</servlet-name>
                <servlet-class>form</servlet-class>
        </servlet>

        <servlet-mapping>
                <servlet-name>Assignment1_6</servlet-name>
                <url-pattern>/form</url-pattern>
        </servlet-mapping>



</web-app>
```