

PHYSICIAN'S STATEMENT

POLICY NO: 0 _____

DRIVER: _____

INSURED: _____

DATE OF BIRTH: _____

TO BE COMPLETED BY A PHYSICIAN:

YES NO

1) DOES THE APPLICANT HAVE ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

a. CARDIO-VASCULAR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
b. DIZZY OR FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
c. ABNORMAL BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
d. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
e. EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>

2) HAS APPLICANT RECENTLY SUFFERED A SERIOUS ILLNESS OF ANY KIND?
IF YES, WHAT ILLNESS?

3) DOES APPLICANT HAVE ANY LOSS OF THE FOLLOWING?

a. LEG	<input type="checkbox"/>	<input type="checkbox"/>
b. FINGERS	<input type="checkbox"/>	<input type="checkbox"/>
c. HAND	<input type="checkbox"/>	<input type="checkbox"/>
d. ARM	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

4) ARE REFLEXES NORMAL?

5) DOES APPLICANT HAVE ANY UNTREATED PARTIAL LOSS OR REDUCTION OF EYESIGHT?

6) DOES APPLICANT HAVE ANY LIMITATION OF PERIPHERAL VISION?

7) DOES APPLICANT HAVE DIFFICULTY DISTINGUISHING RED FROM GREEN?

8) DATE OF PHYSICAL EXAMINATION

9) AS OF THE DATE OF THE LAST EXAMINATION IS THE APPLICANT'S GENERAL PHYSICAL AND MENTAL CONDITION SUCH AS TO IMPAIR THE OPERATION OF AN AUTOMOBILE?

ADDITIONAL COMMENTS: _____

IMPORTANT: THIS FORM MUST BE SIGNED BY THE EXAMINING PHYSICIAN.

PRINT PHYSICIAN'S NAME

DATE OF REPORT

ADDRESS

Physician's Signature