PHYSICIAN'S STATEMENT

Policy No: _____ Driver: _____

Named Insured: _____ Date of Birth: _____

To be completed by Physician

	YES	NO
1. Does applicant have any of the following diseases or conditions?		
a. Cardio-vascular disease	☐	☐
b. Dizzy or fainting spells	☐	☐
c. Abnormal blood pressure	☐	☐
d. Alcoholism or drug addiction	☐	☐
e. Diabetes	☐	☐
f. Epilepsy	☐	☐
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	☐	☐
b. Fingers	☐	☐
c. Hand	☐	☐
d. Arm	☐	☐
e. Foot	☐	☐
4. Are reflexes normal?	☐	☐
5. Does applicant have any uncorrected 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. Please give visual acuity:

	Natural	Corrected
Left	20/ __	20/ __
Right	20/ __	20/ __
Both eyes	20/ __	20/ __

9. Date of last physical examination: _____

	YES	NO
10. As of the date of the last examination, is applicant's general physical and mental condition such as to IMPAIR safe operation of an automobile?	☐	☐

Additional comments: _____

_____

_____

Important: This form must be signed by the examining physician.

_____ _____

Physician's Signature Date of Report

_____

Address

_____

CA-STMT-3 (1-92)