Name of Insured or Applicant		Date of Birth	Policy Number
Address	City and State		Zip Code

SECTION 1: MUST BE COMPLETED BY PHYSICIAN

DOES DRIVER HAVE A HISTORY OF:

1. Dizzy or fainting spells YES OR NO
2. Diabates YES OR NO
3. Cerebro-vascular hemorrhage YES OR NO
4. Epilepsy YES OR NO
5. Attack of unconsciousness or convulsions YES OR NO
6. Any other serious injury YES OR NO
7. Heart attack, heart condition or cardiovascular disease YES OR NO (if yes, complete the following):
   A. Date of first attack_____ B. Date of last attack_____
8. Does driver have a history of high blood pressure? YES OR NO
9. Has driver been advised to restrict activities? YES OR NO
10. Is driver taking any medication that might affect driving abilities? YES OR NO
11. Is there any mental or nervous disorder that would impair ability to drive safely? YES OR NO
12. Are there any other bodily defects or limitations that are likely to hinder safe driving? YES OR NO
13. Does driver suffer from Cataracts? YES OR NO
14. Does driver have full use of muscular coordination in all extremities? YES OR NO

If no, please explain:_____

_____

What is your opinion as to driver's ability to safely operate a vehicle?

Above Average_____ Average_____ Below Average_____

_____ _____

STAMP/PRINT NAME OF PHYSICIAN SIGNATURE OF PHYSICIAN DATE

SECTION II: TO BE COMPLETED BY INSURED/APPLICANT

1. How long have you been licensed?_____ 2. Date of last license examination_____ 3. Do you practice any self-imposed restrictions on your driving? YES NO (If yes, explain)_____

_____.

4. Has the vehicle been altered to compensate for any impairment(s)? YES NO (If yes, describe)_____

5. Do you hold a commercial driver's license? YES NO 6. How long have you been operating this type of commercial vehicle?_____

_____

SIGNATURE OF INSURED/APPLICANT DATE

MEDICAL STATEMENT