



MEDICAL REPORT FOR AUTOMOBILE INSURANCE

NAME OF APPLICANT: _____

ADDRESS OF APPLICANT: _____

_____ Date of Birth: _____

Is applicant actively employed? Yes No

If yes, indicate type of work. _____

Is there any other driver 70 years of age or older? Yes No

If yes, supply name and date of birth. _____

If more than one driver is over the age of 65 yrs and older a separate report on each individual must be completed.

Applicant's Authorization to his Physician

I hereby authorize you to complete for RoyalStar Assurance Ltd., the following report on my physical condition.

Applicant's Signature

Date

To be completed by the Physician (if an answer is 'Yes' to any of the following, please explain briefly).

Does the applicant have a total loss or an uncorrected partial loss of or reduction in hearing?

Yes No

Has the applicant lost the use of a hand, an arm, a leg, or an eye? Yes No

Has the applicant had any cardio-vascular disease? Yes No

Has the applicant had dizziness or fainting spells? Yes No

Has the applicant recently suffered a serious illness of any kind? Yes No

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Does the applicant have diabetes? Yes No

Does the applicant have epilepsy? Yes No

Is the Applicant currently taking any prescribed medication? Yes No

Does the applicant have any uncorrected partial loss or reduction of eyesight? Yes No

Is there any limitation of peripheral vision or any opacity of the crystalline lens of either or both eyes? Yes No

Does the applicant have any difficulty distinguishing red from green? Yes No

Please supply visual acuity:

Natural	Left 20/	Right 20/	Both Eyes 20/
Corrected	Left 20/	Right 20/	Both Eyes 20/

Date of Applicant's last physical exam:

As of the date of the last examination, are you satisfied that the Applicant's general physical and mental conditions are such that he can safely operate an automobile? Yes No

Additional comments: _____

Date: _____

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Physician's Full Name & Address