American European Insurance Company
Medical Report for Automobile Insurance

Name of Applicant _____ Date of Birth _____ Insurance Agency _____

I hereby authorize you to complete this report on my physical condition for American European Insurance Company.

Applicant's Signature _____ Date _____

To Be Completed By Physician

1. Does your patient have any uncorrected eye vision problems that affect his/her ability to drive? Yes____No_____
If yes, please describe: _____

2. Are there any physical disabilities that might reduce driving ability (paralysis, amputations, weaknesses, arthritis, etc.)? Yes_____No_____
If yes, please describe and indicate how long he/she has been driving with this disability:_____

3. Is your patient unable to drive safely due to impaired mental capacity or diminished alertness? Yes_No_____
If yes, please describe: _____

4. Is your patient on any medication that will adversely affect his/her ability to operate a motor vehicle? Yes____No_____
If yes, please describe _____

5. Are you aware of anything else about your patient that could affect his/her ability to drive safely (alcohol problems, drug problems, emotional problems, diabetes, epilepsy, etc.)? Yes_____No____
If yes, please describe:_____

If additional space is needed for any of the questions above, please use the reverse side of this form.

Physician's Name (Please Print) _____ Physician's Signature _____

Street Address _____ Date _____

City/State/Zip _____