HUDSON INSURANCE GROUP
2280 WARDLOW CIRCLE, SUITE 205
CORONA, CA 92880

PHYSICIAN'S OPINION STATEMENT - DRIVER FITNESS

On _____ I completed a physical examination of_____date of birth_____to determine his or her mental and physical fitness to operate a motor vehicle. MUST BE COMPLETED NO MORE THAN 6 MONTHS PRIOR TO POLICY EFFECTIVE DATE. My findings are as follows:

General Health

1. Is there any nervous, organic, or functional disease which has advanced, or is likely to advance during the next 12 months, to a degree that will interfere with safe driving? ❑ Yes ❑ No
2. Has the applicant ever been treated or received medication for any nervous, neurological, mental or emotional disorders? _____ ❑ Yes ❑ No
3. Has the applicant ever been treated for epilepsy? ❑ Yes ❑ No

Mental Condition

4. Has a loss of alertness or mental activity adversely affected the applicant's ability to handle emergencies frequently encountered in driving? ❑ Yes ❑ No

Physical Condition

5. Has the applicant lost any extremities or limbs? _____ ❑ Yes ❑ No
   a. Is there any partial or total loss of use of any extremity or limb that impairs safe driving ability? ❑ Yes ❑ No
   b. Is there any other bodily defect or limitation that is likely to hinder safe driving? ❑ Yes ❑ No
   c. Does the car have special controls? Details: _____ ❑ Yes ❑ No

Hearing

6. Any hearing loss which could interfere with safe driving? ❑ Yes ❑ No

Vision

7. Does the applicant have cataracts which have not been repaired? ❑ Yes ❑ No
8. Is peripheral (side) vision restricted? ❑ Yes ❑ No
9. Has the applicant lost the use of either eye? ❑ Yes ❑ No
10. Is there any opacity of the crystalline lenses of either or both eyes? ❑ Yes ❑ No
11. Visual Acuity With or Without Corrective Lenses
    Both Eyes if same: 20/_____ Left Eye: 20/_____ Right Eye: 20/ _____
12. Date of last eye examination. _____
13. Do the above visual acuity ratings suggest an inability to safely operate a motor vehicle? ❑ Yes ❑ No

Summary

14. Please explain any "Yes" answers above: _____
    _____
    _____
15. Circle if applicable, and indicate date of last treatment (Convulsions, Loss of Equilibrium, Alcohol/Drug Abuse, Mental/Emotional Illness, Fainting Spells):_____
16. Are there any restrictions on your drivers' license other than glasses/contact lenses? ❑ Yes ❑ No
    If yes, please give details: _____
17. Are there any conditions, not mentioned above, that could affect the applicant's ability to drive? ❑ Yes ❑ No
    If yes, please give details: _____

_____ Signature of Examining Physician

_____ Signature of Applicant

Print Physician's Name:_____ Policy Number: _____

** Please see the reverse side for important privacy information.*

HUDSON INSURANCE GROUP
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