IMPORTANT – To be completed by the Insurance Agent
Policyholder Name ______________________________
Policy Number __________________________

Dear Doctor:

As we consider providing coverage for this driver of an insured motor vehicle, we would like to get some information regarding your patient. We would appreciate it if you would answer the following questions:

_ _

PHYSICIAN'S REPORT OF DRIVER FITNESS

Patient: ____ Age: _______

HISTORY: (If "yes," please explain current condition and treatment in Comments section below)

		Yes	**No**
1.	Diabetes	☐	☐
2.	Dizzy or Fainting Spells, Convulsions, or Epilepsy	☐	☐
3.	Parkinson Disease	☐	☐
4.	Mental/Nervous Disorder	☐	☐
5.	Multiple Sclerosis	☐	☐
6.	Cerebro-Vascular Hemorrhage or Stroke	☐	☐
7.	Heart Attack, Heart Condition, or Cardiovascular Disease	☐	☐
8.	Hearing or Visual Impairment	☐	☐
9.	Back or Neck Problems	☐	☐
10.	Any loss or limitation of use in any extremity?	☐	☐
11.	Any other significant illness or health condition?	☐	☐

COMMENTS:

		Yes	**No**
1.	Your medical opinion as to his/her ability to operate a motor vehicle?	☐	☐
2.	Your medical opinion as to his/her ability to operate a 15-Passenger Van or Multi-Passenger Bus	☐	☐

X ______________________________ ______________________ __________

Signature of Doctor License No. Date

MEDICAL AUTHORIZATION

I authorize my Doctor to furnish to GuideOne Mutual Insurance Company, and all of its Affiliated Companies, the information requested above.

I understand this information will be used for evaluating my eligibility as an approved driver and this authorization shall remain valid for one year unless revoked by written notice to the Company. I have received a copy of this authorization.

X ____ ______________

Signature of Patient Date