

**PHYSICIAN'S OPINION STATEMENT - DRIVER FITNESS**

On \_\_\_\_\_ I examined \_\_\_\_\_ date of birth \_\_\_\_\_  
(Date)

to determine his or her mental and physical fitness to operate a motor vehicle. 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. Does the applicant need a hearing aid to hear ordinary conversation?  Yes  No

**Vision**

7. Has the applicant have ever had cataracts?  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 Corrective Lenses  
Both Eyes if same: 20/\_\_\_\_\_ Left Eye: 20/\_\_\_\_\_ Right Eye: 20/ \_\_\_\_\_
12. Date of last 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): \_\_\_\_\_ Last Complete Physical Exam: \_\_\_\_\_

16. Are there any restrictions on your drivers' license other than glasses/contact lenses?  Yes  No  
If yes, please give details: \_\_\_\_\_

17. Is the applicant under the care of a physician for any condition not mentioned above?  Yes  No  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Signature of Applicant

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## **HUDSON INSURANCE GROUP**

### **Privacy Notice**

To Our Customers:

You provide us with most of the information about you that we use in evaluating your application and servicing your insurance policy. We may collect non-public personal information about you from any of the following sources: Information from you on your application and other forms; Information about your transactions with Hudson Insurance Group, our affiliates or others; and information we receive from a consumer reporting agency. Depending on the nature of your coverage, we may collect information about you from third parties, such as other persons proposed for coverage under your policy or the State Motor Vehicle Department concerning your driving record.

We do not disclose any non-public information about our customers or former customers to anyone, except (i) for our everyday business purposes such as to process insurance transactions, maintain and adjust claims, respond to court orders and legal investigations, or (ii) as otherwise permitted by law. In some cases this may mean information can be disclosed to third parties without your authorization.

We restrict access to information about you to employees who need to know in order to provide you with products or to provide you benefits or services under them. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your non-public personal information.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

We would be pleased to tell you about our policies and procedures for the privacy of your information. For a copy of our privacy policy or to access your information, please contact us at:

Hudson Insurance Group  
100 William Street, 5<sup>th</sup> Floor  
New York, NY 10038  
Tel. (212) 978-2800  
Fax. (212) 344-2973  
[www.hudsoninsgroup.com](http://www.hudsoninsgroup.com)