PARAGON INSURANCE GROUP

Physician's Statement

Date: / /
PRODUCER NAME AND ADDRESS
CODE:

NOTE TO THE PHYSICIAN: The purpose of this statement is to help the compar determine the applicant's general physical condition or state of heal

APPLICANT INFORMATION

Name First Middle Last			Policy number
Address City State Zip			Home Telephone
Company/Plan	NEW ❑ YES ❑ NO RENEWAL ❑ YES ❑ NO	Effective Date	Expiration Date

GENERAL INFORMATION

Date of Birth / /	Age	Sex	Occupation			Employer's Name and Address
Name of Family Doctor and Address						
		Height	Weight	Yrs. under Phy. Care	Date of Last Visit	
Phone:						

Medical History

EYESIGHT - Does the Applicant:	YES	NO
1) Have lost use/sight of either eye?	❑	❑
2) Have peripheral (side) vision restriction?	❑	❑
3) Have or ever had cataracts?	❑	❑
4) Have sight deficiencies corrected by glasses/contacts?	❑	❑
5) Date of last eye examination ______/______/______		
6) Vision without glasses: R20/_____ L20/_____		
Vision with glasses: R20/_____ L20/_____		

HEARING - Does the Applicant:	YES	NO
1) Hear normal conversation level?	❑	❑
2) Use a hearing aid?	❑	❑

HEART - Does/Has the Applicant:	YES	NO
1) Ever been treated for heart disease?	❑	❑
2) Ever had a heart attack? Date of Last _____/_____/_____	❑	❑
3) Have a pacemaker?	❑	❑
5) When was last treatment or check-up? _____/_____/_____		
4) Medication/Dosage used? ____________________	❑	❑

LIMBS - Does/Has the Applicant:	YES	NO
1) Lost and arm or leg?	❑	❑
2) Lost the use of an arm or leg?	❑	❑
3) Have a car that has special controls?	❑	❑
4) If any of the above describe: ____________________		

DIABETES - Does/Has the Applicant:	YES	NO
1) Ever been tested for Diabetes?	❑	❑
2) Latest Blood/Sugar test date ____________________		
3) Medication/Dosage used ____________________		
4) Method of administration ____________________		

EPILEPSY/SEIZURE - Does/Has the Applicant:	YES	NO
1) Ever been treated for Epilepsy?	❑	❑
2) If yes, kind and date of last seizure. ____________________		
3) Medication/Dosage used ____________________		

BLOOD PRESSURE - Does/Has the Applicant:	YES	NO
1) Ever been treated for high blood pressure?	❑	❑
2) If yes, date of treatment. ____________________		
3) Last reading. ____________________		
4) Medication/Dosage used: ____________________		

MISCELLANEOUS (indicate date of last treatment, if applicable).
Does/Has the Applicant:

1) Convulsions ____________________
2) Fainting Spells ____________________
3) Loss of Equilibrium ____________________
4) Alcohol/Drug Abuse ____________________
5) Mental/Emotional Illness ____________________
6) Complete Physical Examination ____________________

(IF ANY "YES" RESPONSES, PLEASE PROVIDE COMPLETE EXPLANATION)

		YES	NO
1)	HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?	❑	❑
2)	HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Etc.)?	❑	❑
3)	ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVER'S LICENSE OTHER THAN GLASSES?	❑	❑
4)	ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE?	❑	❑

5) PLEASE DESCRIBE ANY OTHER PHYSICAL, MENTAL, OR MEDICAL LIMITATION NOT LISTED ABOVE; OR USE FOR ANY FURTHER EXPLANATIONS:

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CONSULTANT

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE AND THAT THE APPLICANT, IN MY OPINION, HAS THE ABILITY TO OPERATE A VEHICLE IN A SAFE MANNER.

______________________________ Signature of Physician

______/______/______ Date