



Chubb Group of Insurance Companies

PHYSICAL REPORT FOR AUTOMOBILE INSURANCE

NAME OF APPLICANT	POLICY NUMBER	AGENTS NUMBER
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NAME OF OPERATOR	DATE OF BIRTH
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Information submitted in an application for automobile insurance indicates that the above named operator has one or more of the conditions enumerated below or, this report is being requested because of the advanced age of this operator.

Please complete the following questionnaire and include a brief explanation of any condition indicated by an affirmative answer, in "Remarks."

TO BE COMPLETED BY PHYSICIAN

Has the Operator any of following conditions:	No	Yes	If "Yes," and condition is consider "Mild" check below:
1. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Fainting or blackouts (syncope)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Disease (excluding murmur)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis (visibly affected)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Neuromuscular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Corrected vision poorer than 20/50 in one or both eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. High blood pressure (180/100 or over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Loss or paralysis of an arm or leg (unless compensated for by vehicular equipment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Any other physical disorder for which a doctor prescribes continuous medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Any mental disorder which, in the last three years, has resulted in: a) Hospitalization b) Continuous treatment involving shock treatment or medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Any other condition for which medically restricted license is required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. In your opinion, is there any medical condition which hampers this operator's driving ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS:

PHYSICIAN'S SIGNATURE	
PHYSICIAN'S ADDRESS	DATE