

Suite 2, Colonial Hill Plaza  
#72 University Drive  
P.O. Box GT-2174  
Nassau, Bahamas



Don't take a chance.  
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## MEDICAL REPORT FOR AUTOMOBILE INSURANCE

**NAME OF APPLICANT:** \_\_\_\_\_

**ADDRESS OF APPLICANT:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Is applicant actively employed?  Yes  No

If yes, indicate type of work. \_\_\_\_\_

Is there any other driver 70 years of age or older?  Yes  No

If yes, supply name and date of birth \_\_\_\_\_

**If more than one driver is over the age of 70, a separate report on each individual must be completed.**

### Applicant's Authorization to Physician

I hereby authorize you to complete for Shield Insurance Agents & Brokers Ltd., the following report on my physical condition.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**To be completed by the Physician (if an answer is 'Yes' to any of the following, please explain briefly).**

**Does the applicant have a total loss or an uncorrected partial loss of or reduction in hearing?**  Yes  No

\_\_\_\_\_

**Has the applicant lost the use of a hand, an arm, a leg, or an eye?**  Yes  No

\_\_\_\_\_

**Has the applicant had any cardio-vascular disease? If yes, indicate date of diagnosis**  Yes  No

\_\_\_\_\_

**Has the applicant had dizziness or fainting spells? If yes, indicate date of diagnosis**  Yes  No

\_\_\_\_\_

**Has the applicant recently suffered a serious illness of any kind? If yes, indicate date of diagnosis**  Yes  No

\_\_\_\_\_



+ Ph: 242-356-7202  
+ Fax: 242-601-5401



www.shieldinsurancebahamas.com  
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Does the applicant have diabetes? If yes, indicate date of diagnosis • Yes • No

\_\_\_\_\_

Does the applicant have epilepsy? If yes, indicate date of diagnosis • Yes • No

\_\_\_\_\_

Is the Applicant currently taking any prescribed medication? • Yes • No

\_\_\_\_\_

Does the applicant have any uncorrected partial loss or reduction of eyesight? • Yes • No

\_\_\_\_\_

Is there any limitation of peripheral vision or any opacity of the crystalline lens of either or both eyes?

• Yes • No

\_\_\_\_\_

Does the applicant have any difficulty distinguishing red from green? • Yes • No

\_\_\_\_\_

Please supply visual acuity:

Natural      Left 20/      Right 20/      Both Eyes 20/

Corrected      Left 20/      Right 20/      Both Eyes 20/

\_\_\_\_\_

Date of Applicant's last physical exam:

\_\_\_\_\_

As of the date of the last examination, are you satisfied that the Applicant's general physical and mental conditions are such that he can safely operate an automobile? • Yes • No

\_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

Physician's Signature Page 2 of 2

Physician's Full Name & Address

Date: \_\_\_\_\_