KEMPER

7595400

Underwritten by American Access Casualty Company

PHYSICIAN'S REPORT

POLICY NUMBER: **PRODUCER NAME:**

NAMED INSURED:

Name of driver for whom this report is being completed:	
Are there any restrictions currently appearing on your driver's license?	☐ Yes ☐ No

I hereby authorize the attending physician to release the following information they have regarding my physical condition while under their observation or treatment. This information will be used in the underwriting of an automobile liability insurance policy with Kemper.

_____ _____

Signature of Driver For Whom This Report Is Being Completed Date

TO BE COMPLETED BY PHYSICIAN (IF ANSWER TO ANY OF THE FOLLOWING IS "YES" PLEASE BRIEFLY EXPLAIN)

1. Has applicant ever suffered from dizziness, fainting or convulsions?	☐ Yes ☐ No
2. Does the applicant have a total loss or an uncorrected partial loss of hearing?	☐ Yes ☐ No
3. Has the applicant recently suffered a serious impairment or illness of any kind?	☐ Yes ☐ No

If Yes:

a. Nature of impairment or illness:

b. Duration of impairment or illness:

c. Medication (type(s) and amount):

d. Date the above individual was last seen by the Physician below for treatment of the above condition(s):

4. In your opinion, will the impairment, illness or prescribed medication adversely affect the ability of the driver listed above to safely operate a motor vehicle? ☐ Yes ☐ No If "YES", please explain:

Physician's Name (Please Print) _____

_____ _____

Physician's Signature Date

TO BE COMPLETED BY PHYSICIAN OR OPTOMETRIST

5. Visual Acuity:	Natural	Left 20/	Right 20/	Both Eyes 20/
	Corrected	Left 20/	Right 20/	Both Eyes 20/

6. Is there any limitation of peripheral vision or any opacity of the crystalline lens of either or both eyes?	☐ Yes ☐ No

Physician's/Optometrist Name (Please Print)

_____

_____ _____

Physician's/Optometrist Signature Date

APP ID Number: