CG | ATLANTIC GENERAL

HEALTH QUESTIONNAIRE

POLICY NO. _____

Road User

PART 1 DETAILS OF INSURED

Full Name _____ Date of Birth (DD/MMM/YY)_____

PART 2 HEALTH QUESTIONS

The Insured and all Additional Drivers must answer the following questions carefully and correctly.

Question:		YES	NO	If YES, please give details:
1.	**VISION** Do you suffer from any vision impairment or disability which is not corrected by lenses?	☐	☐	
2.	**HEARING** Do you suffer from any hearing impairment or disability which is not corrected by use of a hearing aid?	☐	☐	
3.	**HEART** Have you ever suffered from any heart complaint or condition (e.g. Angina/ Hypertension,etc.)?	☐	☐	
4.	**DIABETES** Do you suffer from Diabetes?	☐	☐	If YES, how is it managed?
5.	**EPILEPSY** Do you suffer from Epilepsy or seizures?	☐	☐	If YES, how is it managed?
6.	**HOSPITALIZATION** Have you been an in-patient during the last 12 months?	☐	☐	If YES, for what reason and are you now fully recovered?
7.	**OTHER AILMENTS** Do you suffer from any other physical or mental ailments, disease or infirmity?	☐	☐	
8.	**MEDICATIONS** Are you on any prescribed medications which may affect your ability to drive?	☐	☐	
9.	**DOCTOR** What is the name of your family physician?			

Insured/Additional Driver Signature(s): _____ Date: _____

PART 3 PHYSICIAN'S DECLARATION

To the best of my knowledge, the patient named above does not suffer from any physical or mental disability which could make it undesirable for them to drive a Motor Vehicle.

Signature: _____ Date: _____ Physician's Stamp required here:

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