Erie Insurance®

PHYSICIAN'S REPORT FOR AUTOMOBILE INSURANCE UNDERWRITING

DIARY

NAME OF POLICYHOLDER/APPLICANT required		NAME OF DRIVER FOR WHOM THIS REPORT IS BEING COMPLETED
POLICY NO. OR POLICY EFFECTIVE DATE	AGENT'S NAME	AGENT'S NO.

NOTE: The policyholder/applicant, not The ERIE, must pay any fees required for completion of this form.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

To: _____
(Name of Medical Provider)

I authorize you to furnish a representative of Erie Insurance* all information requested in the "Physician's Report for Automobile Insurance Underwriting" form on the reverse side for use in underwriting my insurance policy with ERIE.

This authorization shall be effective for a period of two years from the date it is signed, unless revoked in writing by the undersigned. A copy of this Authorization shall be as valid as the original.

HIPAA Notice: I understand that if I direct my health information to be disclosed to an entity not covered by the Privacy regulations of the Health Insurance Portability and Accountability Act (covered entities include health plans, health care providers and health care clearinghouses), Federal law might not protect it and the recipient might redisclose it.

Name: _____
(First, Middle, Last)

Date of Birth: _____

Social Security No.: _____

Signature: _____ Date: _____

_____
(Print Name)

_____
(If a minor, include signature of parent or guardian; if other personal representative, attach supporting documentation)

*Erie Insurance includes Erie Insurance Exchange, Erie Insurance Company, Erie Insurance Property & Casualty Company, Erie Insurance Company of New York and Flagship City Insurance Company.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

CONTINUED ON REVERSE SIDE

TO BE COMPLETED BY PHYSICIAN: (PLEASE PRINT CLEARLY OR TYPE YOUR RESPONSE)

1. NATURE OF IMPAIRMENT OR ILLNESS

_____

_____

2. DURATION OF IMPAIRMENT OR ILLNESS

_____

_____

3. MEDICATION (TYPE(S) AND DOSAGE(S))

_____

_____

4. IN YOUR OPINION, DOES THE IMPAIRMENT, ILLNESS OR PRESCRIBED MEDICATION ADVERSELY AFFECT THE ABILITY OF THE DRIVER LISTED ABOVE TO SAFELY OPERATE A MOTOR VEHICLE?

☐ NO

☐ YES IF "YES," PLEASE EXPLAIN:

_____

_____

5. IN YOUR OPINION, IS THERE A LIKELIHOOD THE IMPAIRMENT OR ILLNESS WILL RENDER THE DRIVER INCAPABLE OF SAFELY OPERATING A MOTOR VEHICLE IN THE FUTURE?

☐ NO

☐ YES IF "YES," PLEASE EXPLAIN:

_____

_____

PHYSICIAN'S SIGNATURE ▶ _____ DATE _____

PHYSICIAN'S NAME (PLEASE PRINT, TYPE OR STAMP) _____

PHYSICIAN'S ADDRESS _____

_____ PHONE _____