PROFESSIONAL ATHLETE'S PROPOSAL / MEDICAL APPLICATION

PROPOSAL FORM

(All questions must be answered in ink)

SECTION 1

PROPOSED INSURED *(To be completed by ALL Proposed Insureds)*

1. Name in full: _____

2. Residential Address: _____

_____

_____

3. Mailing Address: _____

(If different from above) _____

_____

4. Date of Birth: _____ 5. Sex: Male ☐ Female ☐

6. Height _____ft _____in. 7. Weight: _____

PROPOSED INSURED'S OCCUPATION *(To be completed by ALL Proposed Insureds)*

1. I participate in (sport) _____ as a… Professional ☐

Collegian ☐

Other (please state) ☐

2. Name of Team: _____

3. Position: _____

4. Do you have any other employment full or part time: Yes ☐ No ☐

If 'Yes', describe _____

(Questions 5 to 11 are not applicable if Collegiate Status)

5. Employer: _____

6. Business Address: _____

_____

7. Nature of Employer's Business: _____

8. Date of expiry of current contract *(if applicable)* _____

9. Are you actively working in your occupation?: Yes ☐ No ☐

If 'No' please give reasons: _____

_____

10. How long have you been working as a professional in this occupation?: _____ years

11. Other Employment, last five years: _____

POLICY OWNER - *Please check* Insured ☐ Other ☐

1. Name and Address of Policy Owner (if other than Proposed Insured): _____

_____

2. Relationship to Proposed Insured: _____

PREVIOUS / OTHER INSURANCES

1. Do you currently have or do you anticipate purchasing any other disability Insurance whether purchased by yourself or any other person on your behalf? Yes ☐ No ☐
   If 'Yes' please give details: _____

   _____

2. Have you during the last five years been insured for disability whether purchased by yourself or any other person on your behalf?: Yes ☐ No ☐
   If 'Yes' please give details: _____

   _____

3. Have you ever had a proposal for disability insurance declined or accepted with special conditions or exclusions imposed Yes ☐ No ☐
   If 'Yes' please give details: _____

   _____

SECTION 2

Do you participate in any of the following?:

a. winter sports, other than skating or curling: Yes ☐ No ☐ If 'Yes', please give details:

_____
_____
_____
_____

b. water or underwater sports: Yes ☐ No ☐ If 'Yes', please give details:

_____
_____
_____
_____

c. rock climbing or mountaineering: Yes ☐ No ☐ If 'Yes', please give details:

_____
_____
_____
_____

d. motor sports or motorcycling: Yes ☐ No ☐ If 'Yes', please give details:

_____
_____
_____
_____

e. any other activities excluded by your club contract: Yes ☐ No ☐ If 'Yes', please give details:

_____
_____
_____
_____

PERSONAL MEDICAL HISTORY FORM

(All questions must be answered in ink)

Wherever 'YES' or 'NO' answers require full details, these should be given in the space provided. However, if there is not sufficient space, please attach your answers on a separate sheet.

SECTION 1

1. Are you at present free of injury, illness of discomfort? Yes ☐ No ☐
   If 'NO', please give full details:

_____

_____

_____

_____

2. Are you currently physically able to perform all of the duties required in your sport as stated in Section 1 of the Proposal Form? Yes ☐ No ☐
   If 'NO', please give full details:

_____

_____

_____

_____

3. Have you missed any playing time during the last 24 months as a result of injury, illness, discomfort or for any other reason? Yes ☐ No ☐
   If 'YES', please give full details:

_____

_____

_____

_____

SECTION 2

1. Name of Personal Physician: _____

   Address: _____

   _____

   If you have consulted your Personal Physician in the last 24 months, please give dates and reason for consultation:

_____

_____

_____

_____

2. Does the physician named in Question 1 above also act as the physician for the team for which you play?: Yes ☐ No ☐

3. Have you consulted your team physician or any other physician in the last 24 months other than for routine examination or team physical? Yes ☐ No ☐
If 'YES', please give details including name and address of physician:

Physician Name: _____

Physician Address: _____

_____

Details: _____

_____

_____

_____

SECTION 3

1. Have you within the last 24 months taken any pain reducing or anti-inflammatory medication? Yes ☐ No ☐ If 'YES', please give details:

_____

_____

_____

_____

2. During the last 12 months have you suffered any injury, sickness or discomfort for which you have not sought: If 'YES', please give details:

a. medical advice? Yes ☐ No ☐ _____

_____

b. diagnosis? Yes ☐ No ☐ _____

_____

c. treatment? Yes ☐ No ☐ _____

_____

3. Have you been advised or do you have reason to believe that you may need medical treatment in the future? Yes ☐ No ☐ If 'YES', please give details:

_____

_____

_____

_____

SECTION 4

1. Have you been advised to have surgery which has Not been undertaken? Yes ☐ No ☐ If 'YES', please give details:

_____

_____

_____

2. Please answer the following questions and give details where appropriate.
Have you ever injured or suffered pain or discomfort, or had surgery to any of the following:
(If you require additional space for your answers please use space provided on Page 8).

			If 'YES' please give details including dates (day/month/year).
a. Head?	Yes ☐	No ☐	a.) _____
b. Neck (cervical spine)?	Yes ☐	No ☐	b.) _____
c. Right Shoulder?	Yes ☐	No ☐	c.) _____
d. Left Shoulder?	Yes ☐	No ☐	d.) _____
e. Chest (including ribs)?	Yes ☐	No ☐	e.) _____
f. Upper Back (Thoracic Spine)?	Yes ☐	No ☐	f.) _____
g. Lower Back? (Lumbar Spine including Coccyx and tail bone)	Yes ☐	No ☐	g.) _____
h. Pelvis/Hips (incl groin - specify side)	Yes ☐	No ☐	h.) _____
i. Abdomen (incl stomach)?	Yes ☐	No ☐	i.) _____
j. Right Arm (incl Elbow)?	Yes ☐	No ☐	j.) _____
k. Left Arm (incl Elbow)?	Yes ☐	No ☐	k.) _____
l. Right Hand (incl wrist, fingers and thumb)?	Yes ☐	No ☐	l.) _____
m. Left Hand (incl wrist, fingers and thumb)?	Yes ☐	No ☐	m.) _____
n. Right Thigh (incl hamstring)?	Yes ☐	No ☐	n.) _____
o. Left Thigh (incl hamstring)?	Yes ☐	No ☐	o.) _____
p. Right Knee?	Yes ☐	No ☐	p.) _____
q. Left Knee?	Yes ☐	No ☐	q.) _____
r. Right Lower Leg (incl ankle and Achilles Tendon)?	Yes ☐	No ☐	r.) _____
s. Left Lower Leg (incl ankle and Achilles Tendon)?	Yes ☐	No ☐	s.) _____

t. Right Foot (incl toes) Yes ☐ No ☐ t.) _____

u. Left Foot (incl toes)? Yes ☐ No ☐ u.) _____

3. Have you suffered any other injuries discomfort or conditions to:

If 'YES' please give details:

a. bones Yes ☐ No ☐ a) _____

b. joints Yes ☐ No ☐ b) _____

c. muscles Yes ☐ No ☐ c) _____

d. nerves Yes ☐ No ☐ d) _____

(e.g. sprains, strains, dislocations, tendonitis, tears, etc.)
Not listed above?

4. Have you ever undergone surgery as a result of sickness or disease or a non-injury condition?

If 'YES' please give details:

Yes ☐ No ☐ _____

5. Have you ever undergone hospitalization or treatment exceeding fourteen (14) days as a result of sickness or disease or a non-injury condition?

If 'YES' please give details:

Yes ☐ No ☐ _____

6. Have you ever been advised that such surgery may be required in the future?

If 'YES' please give details:

Yes ☐ No ☐ _____

7. Have you been prescribed any of the following treatments or tests ?

If 'YES' please give details of such and dates :

a. medication ? Yes ☐ No ☐ a) _____

b. diagnostic tests ? Yes ☐ No ☐ b) _____

c. surgery ? Yes ☐ No ☐ c) _____
_____

8. Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any conditions of the following?

If 'YES' please give details:

a. Ears, eyes, nose or throat? Yes ☐ No ☐ a.) _____
_____

b. Heart, chest, circulatory system and respiratory system? Yes ☐ No ☐ b.) _____
_____

c. Blood pressure or diabetes? Yes ☐ No ☐ c.) _____
_____

d. Stomach or bladder? Yes ☐ No ☐ d.) _____
_____

e. Dizziness or fainting? Yes ☐ No ☐ e.) _____
_____

f. Gout? Yes ☐ No ☐ f.) _____
_____

g. Hernias? Yes ☐ No ☐ g.)_____
_____

h. Cancer and related diseases? Yes ☐ No ☐ h.)_____
_____

i. Rheumatism or arthritis? Yes ☐ No ☐ i.) _____
_____

j. Liver, kidneys or digestive organs? Yes ☐ No ☐ j.) _____
_____

k. Nervous system, epilepsy or mental disorders, seizures or convulsions? Yes ☐ No ☐ k.) _____
_____

l. Concussions ? Yes ☐ No ☐ l.) _____
_____

m. Paralysis whether complete or partial, regardless of length of time or duration? Yes ☐ No ☐ m.) _____
_____

n. Thyroid Problem? Yes ☐ No ☐ n.) _____
_____

9. Have you suffered any sickness not associated with any of the above which resulted in confinement of greater than seven (7) days?

If 'YES' please give details:

Yes ☐ No ☐ _____
_____
_____
_____

10. Please give details of any family history of any of the conditions mentioned under Question 8 above, and relationship. (i.e. mother, father, brother etc.)

If 'YES' please give details:

Yes ☐ No ☐ _____
_____
_____
_____

Give complete details of any 'YES' or 'NO' answers to questions in the Personal Medical History Form. (attach a separate sheet if necessary)

Section #	Question #	Date	Details – include diagnosis, treatment, duration and results	Name and address of doctor and medical facility

IT IS UNDERSTOOD AND AGREED AS FOLLOWS:

1. I have read the statements and answers recorded herein. They are to the best of my knowledge and belief, true and complete and correctly recorded. Underwriters will rely on this information in making their determinations.

2. No agent, broker or medical examiner has authority to waive the answers to any question, to determine insurability, to waive any of the Underwriters rights or requirements, or to make or alter any contract or policy.

3. The Underwriter has the right to require medical exams and tests to determine insurability.

4. The insurance applied for will not take effect unless the health of the Proposed Insured remains as stated in the Application on the inception date of the proposed policy.

AUTHORISATION TO OBTAIN INFORMATION:

To all physician; medical professionals; hospitals; clinics; other health care providers; insurers; employers; Medical Information Bureau (MIB); consumer reporting agencies; other insurance support organisations; and other persons who have information about the proposed insured:

I authorise you to give Lloyds of London, its reinsurers, its agents (a) all information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physician or mental conditions of the proposed insured; and (b) any non-medical information, including an investigative consumer report, which the company believes it needs to perform the business functions described below.

The information obtained will be used to determine if the proposed insured is eligible for (a) the insurance requested; or (b) benefits under a policy which is in force. It will also be used for any other business purpose which relates to the insurance requested or the policy which is in force.

The form will be valid for 36 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

_____ _____

DATE SIGNATURE OF PROPOSED INSURED

The following declaration is ONLY to be completed where a team is effecting this insurance on behalf of a player:-

We hereby warrant that to the best of our understanding and belief all the answers and statements herein contained are full, complete and true and have been correctly recorded and we do not know of any other information which is likely to influence the decision of the Underwriters and that we are willing to accept a Policy, subject to the terms and conditions of such Policy, to be issued on the basis of an in consideration of the proposal, which we understand shall be attached to and constitute a part of the contact of insurance.

_____ _____ _____

SIGNATURE OF CLUB OFFICIAL DATED POSITION HELD

MEDICAL EXAMINER'S REPORT FORM

(all questions must be answered in ink)

ALL following section to be completed by Medical Examiner on examination of player.

SECTION 1

PROPOSED INSURED

1. Name in full: _____

2. Date of Birth / Age: _____

3. Name of Team: _____ ☐ Professional ☐ College ☐ Other (Please State) _____

4. Position: _____

5. Have you examined and/or treated this patient in the past?

☐ YES, for ____ (number of) years
☐ NO

SECTION 2

Please answer the following questions and give details and dates where appropriate. If there is not sufficient space, please use space provided on page 10 or attach your answers on a separate sheet.

Has the proposed insured suffered discomfort, injury or required treatment to any of the following?

HEAD **YES** ☐ **NO** ☐		**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery:
		Current Prognosis:

NECK (cervical spine) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT SHOULDER ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT SHOULDER ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

CHEST (including ribs) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

UPPER BACK (Thoracic Spine) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

UPPER BACK (Lumbar Spine including Coccyx and tail bone) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

PELVIS/HIPS ☐ **YES** ☐ **NO** **(including groin – specify side)**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

ABDOMEN ☐ **YES** ☐ **NO** **(including stomach)**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT ARM ☐ **YES** ☐ **NO** **(including elbow)**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT ARM ☐ **YES** ☐ **NO** **(including elbow)**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT HAND ☐ **YES** ☐ **NO** **(including wrist, fingers and thumb)**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT HAND YES ☐ **NO** ☐ **(including wrist, fingers and thumb)**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT THIGH (including hamstring) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT THIGH (including hamstring) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT KNEE ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT KNEE ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT LOWER LEG (including ankle and Achilles tendon) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT LOWER LEG (including ankle and Achilles tendon) ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

RIGHT FOOT ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

LEFT FOOT ☐ **YES** ☐ **NO**	**NORMAL EXAM RESULT YES** ☐ **NO** ☐
Date(s) Details (discomfort, injury or treatment)	Details of any surgery:
	Current Prognosis:

SECTION 3

1. Height _____ 2. Weight _____

3. Blood Pressure _____ 4. Pulse _____

5. Please check appropriate box:

	Normal	Abnormal	Comments
Head, ears, eyes, nose & throat?	☐	☐	_____ _____
Skin?	☐	☐	_____ _____
Lungs?	☐	☐	_____ _____
EKG?	☐	☐	_____ _____
Abdomen?	☐	☐	_____ _____
Genitalia?	☐	☐	_____ _____

On completion of physical examination, overall impression with regard to player's ability to continue his career:

_____
_____
_____
_____
_____

As a physician, please state your relationship to the proposed insured, i.e. Personal Physician, Team Physician etc?

_____

I certify that I made this examination at _____ ☐ am ☐ pm

on the _____ day of _____ year of _____

Examination made at ☐ my office, ☐ individual's office, ☐ individual's home, ☐ other - _____

_____
EXAMINERS SIGNATURE

_____
APPLICANTS SIGNATURE

Examiners Address: _____
_____
_____
_____

_____
APPLICANTS FULL NAME

Give complete details of any 'YES' or 'NO' answers to questions in the Personal Medical History Form. (attach a separate sheet if necessary)

Section #	Question #	Date	Details – include diagnosis, treatment, duration and results	Name and address of doctor and medical facility