

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 _____
- (Question 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: _____

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 or discomfort?
If 'NO', please give full details.

Yes No

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. If 'NO', please give details.

Yes No

3. Have you missed any playing time during the last 24 months as a result of injury, illness, discomfort or for any other reason? If 'YES', please give details.

Yes No

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

PROPOSED INSURED: _____ Date of Birth: ____ / ____ / ____

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's Name _____
 Physician's 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 twelve (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 ever been advised to have surgery which has not been undertaken? Yes No If YES, please give details

PROPOSED INSURED: _____ Date of Birth: ____ / ____ / ____

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 (Lumber Spine including Coccyx and tail bone)? Yes No g)
- h) Pelvis/Hips (including groin - specify side)? Yes No h)
- i) Abdomen (including stomach)? Yes No i)
- j) Right Arm (including elbow)? Yes No j)
- k) Left Arm (including elbow)? Yes No k)
- l) Right Hand (including wrist, fingers and thumb)? Yes No l)
- m) Left Hand (including wrist, fingers and thumb)? Yes No m)
- n) Right Thigh (including hamstring)? Yes No n)
- o) Left Thigh (including hamstring)? Yes No o)
- p) Right Knee? Yes No p)
- q) Left Knee? Yes No q)
- r) Right Lower Leg (including ankle and Achilles tendon)? Yes No r)
- s) Left Lower Leg (including ankle and Achilles tendon)? Yes No s)
- t) Right Foot (including toes)? Yes No t)
- u) Left Foot (including toes)? Yes No u)

PROPOSED INSURED: _____ Date of Birth: / /

<p>3. Have you suffered any other injuries discomfort or conditions to:</p>	<p>If YES, please give details</p>	
<p>a) bones <input type="checkbox"/> Yes <input type="checkbox"/> No a) _____</p>		
<p>b) joints <input type="checkbox"/> Yes <input type="checkbox"/> No b) _____</p>		
<p>c) muscles <input type="checkbox"/> Yes <input type="checkbox"/> No c) _____</p>		
<p>d) nerves <input type="checkbox"/> Yes <input type="checkbox"/> No d) _____</p>		
<p>4. Have you ever undergone surgery as a result of sickness or disease or a non-injury condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
	<p>If YES, please give details</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>5. Have you ever undergone hospitalization or treatment exceeding fourteen (14) days as a result of sickness or disease or a non-injury condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
	<p>If YES, please give details</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>6. Have you ever been advised that such surgery may be required in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
	<p>If YES, please give details</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>7. Have you ever been prescribed any of the following which have not been undertaken?</p>		
<p>a) medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If YES, please give details</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>b) diagnostic tests? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>c) surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

<p>PROPOSED INSURED: _____</p>	<p>Date of Birth: / /</p>
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8. Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any of the following?

If YES, please give details

- a. Ears, eyes, nose, or throat? Yes No _____
- b. Heart, chest, circulatory system and respiratory system? Yes No _____
- c. Blood pressure or diabetes? Yes No _____
- d. Stomach or bladder? Yes No _____
- e. Dizziness or fainting? Yes No _____
- f. Gout? Yes No _____
- g. Hernias? Yes No _____
- h. Cancer and related diseases? Yes No _____
- i. Rheumatism or arthritis? Yes No _____
- j. Liver, kidneys and digestive organs? Yes No _____
- k. Nervous system, epilepsy or mental disorders, or seizures or convulsions? Yes No _____
- l. Concussions? Yes No _____
- m. Paralysis whether complete or partial, regardless of length of time or duration? Yes No _____
- n. Thyroid problem? Yes No _____

9. Have you suffered any sickness not associated with any of the above which resulted in confinement of greater than seven (7) days? Yes No _____

If YES, please give details

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.) _____

PROPOSED INSURED: _____	Date of Birth: / /
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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.

AUTHORIZATION TO OBTAIN INFORMATION

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

I authorize you to give Lloyd's 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 physical or mental condition 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 and in consideration of the proposal, which we understand shall be attached to and constitute a part of the contract of insurance.

SIGNATURE OF CLUB OFFICIAL	DATE	POSITION HELD
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PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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