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: _____

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

PROPOSED INSURED:	Date of Birth: / /

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: / /

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)
4. Have you ever undergone surgery as a result of sickness or disease or a non-injury condition?	☐ Yes	☐ No	If YES, please give details
5. Have you ever undergone hospitalization or treatment exceeding fourteen (14) days as a result of sickness or disease or a non-injury condition?	☐ Yes	☐ No	If YES, please give details
6. Have you ever been advised that such surgery may be required in the future?	☐ Yes	☐ No	If YES, please give details
7. Have you ever been prescribed any of the following which have not been undertaken?			If YES, please give details
a) medication?	☐ Yes	☐ No	
b) diagnostic tests?	☐ Yes	☐ No	
c) surgery?	☐ Yes	☐ No	

PROPOSED INSURED: _____	Date of Birth: / /

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: / /

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

Sect#	*Qu#*	*Details - include diagnosis, treatment, duration and results*	*Name and address of doctor and medical facility*

PROPOSED INSURED: _____	Date of Birth: / /

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

PROPOSED INSURED: _____ Date of Birth: / /