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## Section 1

Name of Proposed Insured \_\_\_\_\_

Address of Proposed Insured \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex:  Male  Female

Height \_\_\_\_\_

Weight \_\_\_\_\_

Proposed Insureds Occupation \_\_\_\_\_

Name of Team \_\_\_\_\_

Position \_\_\_\_\_

Do you have any other full or part-time employment?  Yes  No

If Yes, describe \_\_\_\_\_

\_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

\_\_\_\_\_

Nature of Business \_\_\_\_\_

Date of Current Contact Expiration \_\_\_\_\_

Are you actively working in this occupation?  Yes  No

If No, describe \_\_\_\_\_

\_\_\_\_\_

How long have you been working as a professional in this occupation? \_\_\_\_\_

Other Past Employment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Next Contact/Year Estimated Salary \$ \_\_\_\_\_

Last Contact/Year Salary Amount \$ \_\_\_\_\_

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## Section 2

Policy Owner:  Insured  Other

If Other, Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of Relationship to Insured Person \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### Section 3

Do you currently have or do you anticipate purchasing any other disability insurance?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

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, describe \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a proposal for disability insurance declined or accepted with special conditions or exclusions imposed?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Do you participate in winter sports other than skating or curling?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Do you participate in water or underwater sports?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Do you participate in rock climbing or mountaineering?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Do you participate in motor sports or motorcycling?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Do you participate in any activities that are excluded under your organization contract?  Yes  No

If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

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### Section 4

Are you at present free of injury, illness or discomfort?  Yes  No

If No, describe \_\_\_\_\_  
\_\_\_\_\_

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Are you currently physically able to perform all of the duties required in your sport?  Yes  No  
If No, describe

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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, describe

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If you have visited your personal physician in the last 24 months, please provide dates and reasons for consultations.

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Name of Personal Physician:

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Address of Personal Physician:

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Does your personal physician also act as the team or organization physician?  Yes  No

Have you consulted your team or organization physician in the last 24 months other than for routine examinations?  Yes  No

If Yes, describe

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Have you within the last 24 months taken any pain reducing medication or anti-inflammatory medication?  Yes  No

If Yes, describe

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Have you within the last 12 months suffered any injury, illness or discomfort for which you have not sought treatment for?  Yes  No

If Yes, describe

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Have you been advised or do you have reason to believe that you will need to seek medical treatment in the future?  Yes  No

If Yes, describe

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Have you been advised to have surgery which has not yet been undertaken?  Yes  No

Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? If Yes, please provide written details and use additional paper if necessary.

A. Head?  Yes  No

- B. Neck (Cervical Spine)?  Yes  No
- C. Right Shoulder?  Yes  No
- D. Left Shoulder?  Yes  No
- E. Chest (Including Ribs)?  Yes  No
- F. Upper Back (Thoracic Spine)?  Yes  No
- G. Lower Back (Lumbar Spine)?  Yes  No
- H. Pelvis or Hips (Including Groin)?  Yes  No
- I. Abdomen (Including Stomach)?  Yes  No
- J. Right Arm (Including Elbow)?  Yes  No
- K. Left Arm (Including Elbow)?  Yes  No
- L. Right Hand (Including Wrist and Fingers)?  Yes  No
- M. Left Hand (Including Wrist and Fingers)?  Yes  No
- N. Right Thigh (Including Hamstring)?  Yes  No
- O. Left Thigh (Including Hamstring)?  Yes  No
- P. Right Knee?  Yes  No
- Q. Left Knee?  Yes  No
- R. Right Lower Leg (Including Ankle)?  Yes  No
- S. Left Lower Leg (Including Ankle)?  Yes  No
- T. Right Foot?  Yes  No
- U. Left Foot?  Yes  No

Have you ever suffered any other injuries, discomfort or conditions to:

- A. Bones?  Yes  No
- B. Joints?  Yes  No
- C. Muscles / Nerves?  Yes  No

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

Yes  No

If Yes, describe

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Have you ever undergone hospitalization or treatment exceeding fourteen days as the result of sickness, disease, or a non-injury?  Yes  No  
If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Have you ever been advised that such surgery may be required in the future?  Yes  No  
If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Have you ever been prescribed any of the following which have not been undertaken?

Medication?  Yes  No  
If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Diagnostic Tests?  Yes  No  
If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Surgery?  Yes  No  
If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

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

Ears, Nose or Throat?  Yes  No  
Respiratory?  Yes  No  
Stomach?  Yes  No  
Gout?  Yes  No  
Cancer or Related Diseases?  Yes  No  
Liver or Kidneys?  Yes  No  
Seizures?  Yes  No  
Concussions?  Yes  No  
Thyroid Problem?  Yes  No

Heart or Chest?  Yes  No  
Blood Pressure?  Yes  No  
Bladder?  Yes  No  
Hernia?  Yes  No  
Arthritis?  Yes  No  
Epilepsy?  Yes  No  
Mental Disorders?  Yes  No  
Paralysis?  Yes  No  
Partial Paralysis?  Yes  No

Have you ever suffered sickness not associated with any of the above, for which resulted in confinement of greater than seven days?  Yes  No  
If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

Please give details of any family history of any of the conditions mentioned under the above previous two questions (ie Mother, Father, Brothers, Sisters).

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## Section 5

Coverage Requested:

- Loss of Future Earnings
- Loss of Endorsements
- College Draft Protection

- Contract Completion
- Cost of Agents/Managers
- High Limit Death & Dismemberment Benefits

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 determination.
2. No agent, broker or medical examiner has the 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 physician's, medical professionals, hospitals, clinics, other health care providers, insurers, employers, Medical Information Bureau (MIB), consumer reporting agencies, other insurance support organizations, and other person who have information about the proposed insured:

I authorize 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 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 THE PROPOSED INSURED

The following declaration is ONLY to be completed where a team or organization 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.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF TEAM / ORGANIZATION OFFICIAL

\_\_\_\_\_  
TITLE