Administrative Offices

PRO FINANCIAL SERVICES, LLC
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Underwritten by
ACE American Insurance Company

MEDICAL EXAMINER'S REPORT

For Athlete's Disability Income Protection

Part II of II

PROPOSED INSURED'S NAME:

_____

PRO FINANCIAL SERVICES, LLC / ACE AMERICAN INSURANCE COMPANY

ATHLETE'S DISABILITY INCOME PROTECTION

(All questions must be answered in ink. Please print clearly.)

Failure to answer all questions completely with full details will result in a delay in underwriting.

Wherever 'Yes' or 'No' answers require full details, these should be given in the space provided.

If there is not sufficient space, use space provided on back page or attach your answers on a separate sheet.

ALL of the following sections must be completed by the Medical Examiner upon examination of the Proposed Insured.

SECTION 1: GENERAL INFORMATION

1. Name of Proposed Insured:

_____ First _____ Middle _____ Last

2. Date of Birth: _____

3. Name of Team: _____

☐ **Professional**
☐ **Collegiate**
☐ **Other (please state)** _____

4. Position: _____

5. Have you examined and/or treated the Proposed Insured in the past?

☐ YES for _____ (number of) years
☐ NO

SECTION 2: MEDICAL HISTORY

Proposed Insured's:

1. **Height:** _____
2. **Weight:** _____
3. **Blood Pressure:** _____
4. **Pulse:** _____

5. Please check the appropriate box: *If any of the items are deemed abnormal please provide clinical definition of abnormality as well as details and results of any diagnostic tests performed.*

	Normal	Abnormal	Details
Head, Eyes, Ears, Nose or Throat:	☐	☐	
Bones, Glands or Skin:	☐	☐	
Lungs or other Respiratory Organs:	☐	☐	
Heart, and the cardiovascular system including blood vessels:	☐	☐	
EKG:	☐	☐	
Stomach or other Abdominal Organs:	☐	☐	
Genito-Urinary Organs (including prostate or hernias):	☐	☐	

For administrative purposes, make sure the Proposed Insured's name and date of birth are filled in at the bottom of **each** of the following pages.

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

Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 3: MEDICAL HISTORY

For Section 3, Questions 1 through 5:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

1. HEAD ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

2. NECK (cervical spine) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

3. RIGHT SHOULDER ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

4. LEFT SHOULDER ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

5. CHEST (including ribs) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

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

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SECTION 3: MEDICAL HISTORY (continued)

For Section 3, Questions 6 through 10:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

6. UPPER BACK (thoracic spine) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

7. LOWER BACK (lumbar spine including coccyx & tail bone) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

8. PELVIS/HIPS (including groin – specify side) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

9. ABDOMEN (including stomach) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

10. RIGHT ARM (including elbow) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

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

Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 3: MEDICAL HISTORY (continued)

For Section 3, Questions 11 through 15:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

11. LEFT ARM (including elbow) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

12. RIGHT HAND (including wrist, fingers and thumb) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

13. LEFT HAND (including wrist, fingers and thumb) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

14. RIGHT THIGH (including hamstring) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

15. LEFT THIGH (including hamstring) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

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

Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 3: MEDICAL HISTORY (continued)

For Section 3, Questions 16 through 20:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

16. RIGHT KNEE ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

17. LEFT KNEE ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

18. 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:

19. 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:

20. RIGHT FOOT (including toes) ☐ Yes ☐ No — Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

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

Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 3: MEDICAL HISTORY (continued)

For Section 3, Question 21:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

21. LEFT FOOT (including toes) ☐ Yes ☐ No

Normal Exam Result? ☐ Yes ☐ No

Date(s):	Details (discomfort, injury or treatment):	Details of any surgery:	Current Prognosis:

SECTION 4

On completion of physical examination, please provide an overall impression with regard to Proposed Insured's ability to continue his or her career.

_____

_____

_____

_____

_____

_____

Please indicate your relationship to the Proposed Insured by checking the appropriate box:

☐ Personal Physician ☐ Team Physician ☐ Other (please specify): _____

I certify that I made this examination at _____ ☐ A.M. ☐ P.M. on the _____ day of _____, 20 _____

Examination made at: ☐ My Office ☐ Proposed Insured's Office ☐ Proposed Insured's Home ☐ Other _____

Examiner's Signature **Date** **Proposed Insured's Signature** **Date**

Examiner's Name (please print) Proposed Insured's Full Name (please print)

Examiner's Address: _____

_____

_____

Examiner's Telephone No.: ( ) _____

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

Failure to answer all questions completely with full details will result in a delay in underwriting.

Give complete details of any “YES” or “NO” answers to questions in the Application (attach separate sheet if necessary).				
Sect. #	Quest. #	Date of Injury/Illness	Details - include diagnosis, treatment, duration and results	Name and address of doctor and medical facility

Please return this page even if it is not filled out. Failure to return this page, even if it is left blank, will be considered an incomplete application.

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