



Administrative Offices

PRO FINANCIAL SERVICES, LLC

500 West Madison Street
Suite 2660
Chicago, Illinois 60661



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1(800) 832-8000



*Underwritten by
ACE American Insurance Company*

APPLICATION

For Athlete's Disability Income Protection Part I of II

When completing this Application, please note that any questions left unanswered (i.e. boxes not checked, full dates not given) will delay the underwriting process and could result in the withdrawal of an offer of insurance by ACE American Insurance Company.

The insurance applied for will take effect on the date coverage is requested provided that:

- written confirmation of the coverage requested is received within three (3) business days in the offices of Pro Financial Services, LLC; and provided further, that:
- all required completed documents and the completed Application are received by Pro Financial Services, LLC within thirty (30) days from date coverage is requested, unless approved otherwise in writing by ACE American Insurance Company or its Managing General Underwriter; and
- the **first premium** is received by Pro Financial Services, LLC within thirty (30) days from date coverage is requested, unless approved otherwise in writing by ACE American Insurance Company or its Managing General Underwriter; and
- all documents have been reviewed and the Application approved by ACE American Insurance Company or its Managing General Underwriter within sixty (60) days from the date coverage is requested.

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 page 9 of 10 or attach your answers on a separate sheet.

SECTION 1: GENERAL INFORMATION

1. Name of Proposed Insured:

_____ First _____ Middle _____ Last

2. Residential Address:

3. Mailing Address:

(If different from residential address)

4. Driver's Lic. No.: _____

State Driver's License Issued in: _____

5. Soc. Sec. No.: _____

6. Date of Birth: _____

Actual Age: _____

7. Sex Male Female

8. Place of Birth:

_____ (City) _____ (State)

9. I participate in:

_____ (Sport)

as a Professional Collegiate

Other: _____

10. Name of Team: _____

11. Position: _____

12. Date of Expiry of current contract (if applicable): _____

13. Are you actively working in your occupation: YES NO

If NO, please give reasons: _____

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

15. Do you have any other employment full or part-time? YES NO

If YES, please describe: _____

16. Employer: _____

17. Employer's Business Address: _____

18. Nature of Employer's Business: _____

POLICY OWNER INFORMATION

19. Policy Owner:

Please Check Proposed Insured Other

20. Name and address of Policy Owner (if other than Proposed Insured):

21. Relationship to Proposed Insured: _____

All questions must be answered in ink by the Proposed Insured. Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 2: GENERAL INFORMATION

<p>1. Do you participate in any of the following?</p> <p><i>If YES, please give full details.</i></p>	<p>a) Winter sports other than skating or curling:</p> <p>_____</p> <p>b) Water or underwater sports:</p> <p>_____</p> <p>c) Rock climbing or mountaineering:</p> <p>_____</p> <p>d) Motor sports or motorcycling:</p> <p>_____</p> <p>e) Any other activities excluded by your Professional Sports contract (if applicable):</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>2. Have you been convicted of two or more moving violations, or had driving privileges suspended or revoked within the last three (3) years?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>3. Are you currently insured under another policy for Disability Income Protection for Accident or Sickness or Disease?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>4. Have you ever made a claim in respect of Disability Income Protection for Accident or Sickness or Disease?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>5. Have you applied for or purchased in the past any Accident or Sickness or Disease Disability Income Protection?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>

PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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6. Has any Insurer ever cancelled or declined to renew your Disability Income Protection for Accident or Sickness or Disease? <i>If YES, please give full details.</i>	Details:	<input type="checkbox"/>	<input type="checkbox"/>
	_____	YES	NO

SECTION 3: PHYSICIAN'S INFORMATION

1. Team Physician's Name: _____
Team Physician's Address:

Have you consulted your team physician in the last twenty-four (24) months other than for routine examination or team physical? YES NO

If YES, please give full details:

2. Personal Physician's Name: _____
Personal Physician's Address:

Have you consulted your personal physician in the last twenty-four (24) months other than for routine examination or team physical? YES NO

If YES, please give full details:

3. Have you consulted any physician, other than team physician or personal physician, in the last twenty-four (24) months? YES NO

If YES, please give full details:

Physician's Name:

Physician's Address:

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

All questions must be answered in ink by the Proposed Insured. Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 4: MEDICAL HISTORY

<p>1. Are you currently free of Injury, Sickness, Disease or Discomfort?</p> <p><i>If NO, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>2. Are you currently physically able to perform all of the duties required in your sport as stated in Section 1?</p> <p><i>If NO, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>3. Have you missed any playing time during the last twenty-four (24) months as a result of Injury, Sickness, Disease, Discomfort or for any other reason?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>

SECTION 5: MEDICAL HISTORY

<p>1. Have you, within the last twenty-four (24) months, taken any pain reducing or anti-inflammatory medication?</p> <p><i>If YES, please give name of medication and reason taken.</i></p>	<p>Name of Medication</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Reason</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>
<p>2. During the last twelve (12) months, have you suffered any Injury, Sickness, Disease or Discomfort for which you have NOT sought:</p> <p><i>If YES, please give full details.</i></p>	<p>a) Medical advice?</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>	
	<p>b) Diagnosis?</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>	
	<p>c) Treatment?</p> <p>_____</p>	<p><input type="checkbox"/> YES</p>	<p><input type="checkbox"/> NO</p>	

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3. Have you been advised, or do you have reason to believe that you may need: <i>If YES, please give full details.</i>	a) Medical treatment in the future? _____ _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	b) Surgical treatment in the future? _____ _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION 6: MEDICAL HISTORY			
1. Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? <i>If YES, please give full details.</i>	a) Head: _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	b) Neck (cervical spine): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	c) Right Shoulder: _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	d) Left Shoulder: _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	e) Chest (including ribs): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	f) Upper Back (thoracic spine): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	g) Lower Back (lumbar spine including coccyx and tail bone): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	h) Pelvis/Hips (including groin – specify side): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	i) Abdomen (including stomach): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	j) Right Arm (including elbow): _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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<p>1. (continued) Have you ever injured or suffered pain or discomfort, or had surgery to any of the following?</p> <p><i>If YES, please give full details.</i></p>	<p>k) Left Arm (including elbow):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>l) Right Hand (including wrist, fingers and thumb):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>m) Left Hand (including wrist, fingers and thumb):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>n) Right Thigh (including hamstring):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>o) Left Thigh (including hamstring):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>p) Right Knee:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>q) Left Knee:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>r) Right Lower Leg (including ankle and Achilles tendon):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>s) Left Lower Leg (including ankle and Achilles tendon):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>t) Right Foot (including toes):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>u) Left Foot (including toes):</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>2. Have you ever injured or suffered pain or discomfort or had surgery to any of the following NOT listed in Section 6, Question 1 (e.g. fractures, sprains, strains, dislocations, tendonitis, tears, etc.)?</p> <p><i>If YES, please give full details.</i></p>	<p>a) Bones:</p> <p>_____</p>	<input type="checkbox"/> YES
<p>b) Joints:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>c) Muscles:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>d) Nerves:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO

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<p>3. During the past five (5) years, have you been diagnosed by a member of the medical profession as having an Immune or Blood Disorder?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>4. Have you ever undergone surgery as a result of a Sickness or Disease or a non-injury condition (e.g. appendectomy, gall bladder, etc.)?</p> <p><i>If YES, please give full details.</i></p>	<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>5. Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any of the following conditions?</p> <p><i>If YES, please give full details.</i></p>	<p>a) Ears, eyes, nose or throat:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>b) Heart, chest, circulatory system or respiratory system:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>c) Blood pressure or diabetes:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>d) Stomach or bladder:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>e) Dizziness or fainting:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>f) Gout:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>g) Hernias:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>h) Cancer or related diseases:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>i) Rheumatism or arthritis:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>j) Liver, kidneys or digestive organs:</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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All questions must be answered in ink by the Proposed Insured. Failure to answer all questions completely with full details will result in a delay in underwriting.

<p>5. (continued) Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any of the following conditions?</p> <p><i>If YES, please give full details.</i></p>	<p>k) Nervous system, epilepsy or mental disorders, or seizures or convulsions:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<p>l) Concussions:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<p>m) Paralysis whether complete or partial, regardless of length of time or duration:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<p>n) Thyroid problem:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<p>6. Has any member of <u>your immediate family</u> (i.e., mother, father, brother, etc.) ever shown indications of, suffered from, been treated for or been prescribed treatment for any of the conditions mentioned under Question 5 from the preceding page?</p> <p><i>If YES, please give full details.</i></p>	<p>Family Member</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Condition(s)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<p>7. Have you ever suffered a Sickness or Disease NOT associated with any of the conditions mentioned under Question 5 which resulted in hospital confinement of greater than seven (7) days?</p> <p><i>If YES, please give full details.</i></p>		<p>Details:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		<input type="checkbox"/> YES
<p>8. Have you ever had any of the following prescribed or advised which have NOT been taken or performed?</p> <p><i>If YES, please give full details.</i></p>	<p>a) Medication:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<p>b) Diagnostic tests:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<p>c) Surgery:</p> <p>_____</p>		<input type="checkbox"/> YES	<input type="checkbox"/> NO	

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. ACE American Insurance Company will rely on this information in making its determinations in regard to insurability.
2. No agent, broker or medical examiner has authority to waive the answers to any question, to determine insurability, to waive any of ACE American Insurance Company's rights or requirements, or to make or alter any contract or policy.
3. ACE American Insurance Company 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 effective date of the proposed policy.
5. The insurance applied for will take effect on the date coverage is requested provided that:
 - written confirmation of the coverage requested is received within three (3) business days in the offices of Pro Financial Services, LLC; and provided further, that:
 - all required completed documents and the completed Application are received by Pro Financial Services, LLC, within thirty (30) days from date coverage is requested, unless approved otherwise in writing by ACE American Insurance Company or its Managing General Underwriter; and
 - the first premium is received by Pro Financial Services, LLC within thirty (30) days from date coverage is requested, unless approved otherwise in writing by ACE American Insurance Company or its Managing General Underwriter; and
 - all documents have been reviewed and the Application approved by ACE American Insurance Company or its Managing General Underwriter within sixty (60) days from the date coverage is requested.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AUTHORIZATION TO OBTAIN INFORMATION

I understand that the insurance applied for will become effective on the date specified by ACE American Insurance Company only if this Application is accepted by ACE American Insurance Company. I represent that to the best of my knowledge and belief all statements and answers recorded on the Application are true and complete.

I hereby authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurer, the Medical Information Bureau, Inc., or an employer that has any health related records or knowledge of me or my dependents, to give to ACE American Insurance Company or its reinsurers, all such information to use to determine eligibility for insurance or for benefits under an existing policy. This Authorization shall be valid for twenty-six (26) months, and a copy shall be as valid as the original. I may receive a copy upon request. I have received and read the Disclosure Notice.

SIGNATURE OF PROPOSED INSURED

Signed at _____ (City, State)

On this _____ day of _____, 20____.

AH-1000

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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 ACE American Insurance Company 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: ____ / ____ / ____

DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. ACE American Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such a company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Under some circumstances, medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The telephone number is 617-426-3660.

ACE American Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

INFORMATION PROCEDURES – We may need to obtain information about you from doctors or others. When necessary, we may disclose information about you to others without specific authorization. You have a right to access and correction with respect to personal information gathered. Details on these procedures will be furnished on request.