

LLOYD'S

Athlete's Disability Application

PROPOSAL

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 Underwriters at Lloyd's, London.

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 Underwriters at Lloyd's, London or their authorized representative; 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 Underwriters at Lloyd's, London or their authorized representative; and
- all required and completed documents have been reviewed and the Application approved by Underwriters at Lloyd's, London or their authorized representative within sixty (60) days from the date all required and completed documents were received in the offices of Pro Financial Services, LLC

COVERED INDIVIDUAL'S NAME:

PROFINANCIALSERVICES

High-Limit Disability Underwriters

Authorized Representative

PRO FINANCIAL SERVICES, LLC

500 West Madison St.
Suite 2660
Chicago,
Illinois 60661



(312) 376-4640
Fax: (312) 376-4668
1 (800) 832-8000

ATHLETE'S DISABILITY APPLICATION - PROPOSAL

(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 or attach your answers on a separate sheet.

SECTION 1 GENERAL INFORMATION

1. Name of Covered Individual:

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:

7. Sex

M

F

8. Place of Birth (City, State or Country):

9. I participate in (Name of 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 HOLDER INFORMATION

19. Policyholder: Please Check Covered Individual Other

20. Name and address of Policyholder (if other than Covered Individual):

21. Relationship to Covered Individual:

(if other than Covered Individual):

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

SECTION 2 GENERAL INFORMATION

<p>1. Do you participate in any of the following?</p> <p><i>If YES, please give full details (such as how often per year, how long you have engaged in this activity, etc.).</i></p>	<p>a) Winter sports other than skating or curling:</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
	<p>b) Water or underwater sports:</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
	<p>c) Rock climbing or mountaineering:</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
	<p>d) Motor sports or motorcycling:</p> <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
	<p>e) Any other activities excluded by your Professional Sports contract (if applicable):</p> <p style="text-align: right;"><input type="checkbox"/> YES <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: <input type="checkbox"/> YES <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: <input type="checkbox"/> YES <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: <input type="checkbox"/> YES <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: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>6. Has any Insurer ever cancelled or declined to renew your Disability Income Protection for Accident or Sickness or Disease?</p> <p><i>If YES, please give full details.</i></p>	<p>Details: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

COVERED INDIVIDUAL:

Date of Birth:

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** include date(s) and reason):

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** (include date(s) and reason)

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** (include date(s) and reason)::

Physician's Name: _____
 Physician's Address: _____

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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)</i></p>	<p>Details:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<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. (Include date(s) and reason.)</i></p>	<p>Details:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<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. (Include number of events/games missed, date(s) and reason.)</i></p>	<p>Details:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COVERED INDIVIDUAL:

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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>	Name of Medication	Reason	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort.)</i></p>	a) Medical advice?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	b) Diagnosis?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	c) Treatment?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>3. Have you been advised, or do you have reason to believe that you may need:</p> <p><i>If YES, please give full details.</i></p>	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

<p>1. 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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)</i></p>	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

COVERED INDIVIDUAL:

Date of Birth:

SECTION 6 MEDICAL HISTORY (continued)

<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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)</i></p>	<p>e) Chest (including ribs):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>f) Upper Back (thoracic spine):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>g) Lower Back (lumbar spine including coccyx and tail bone):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>h) Pelvis/Hips (including groin - specify side):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>i) Abdomen (including stomach):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>j) Right Arm (including elbow):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>k) Left Arm (including elbow):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>l) Right Hand (including wrist, fingers and thumb):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>m) Left Hand (including wrist, fingers and thumb):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>n) Right Thigh (including hamstring):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>o) Left Thigh (including hamstring):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>p) Right Knee:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>q) Left Knee:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

COVERED INDIVIDUAL:

Date of Birth:

SECTION 6 MEDICAL HISTORY (continued)

<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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)</i></p>	<p>r) Right Lower Leg (including ankle and Achilles tendon):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>s) Left Lower Leg (including ankle and Achilles tendon):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>t) Right Foot (including toes):</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>u) Left Foot (including toes):</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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)</i></p>	<p>a) Bones:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>b) Joints:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>c) Muscles:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>d) Nerves:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<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, including date(s).</i></p>	<p>Details:</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 including date(s).</i></p>	<p>Details:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COVERED INDIVIDUAL:

Date of Birth:

SECTION 6 MEDICAL HISTORY (continued)

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

*If YES, please give **full details**.
(Include date(s), diagnosis, treatment, duration and results.)*

a) Ears, eyes, nose or throat:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b) Heart, chest, circulatory system or respiratory system:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c) Blood pressure or diabetes:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d) Stomach or bladder:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e) Dizziness or fainting:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f) Gout:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g) Hernias:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h) Cancer or related diseases:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i) Rheumatism or arthritis:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j) Liver, kidneys or digestive organs:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k) Nervous system, epilepsy or mental disorders, or seizures or convulsions:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
l) Concussions:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
m) Paralysis whether complete or partial, regardless of length of time or duration:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
n) Thyroid problem:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COVERED INDIVIDUAL:

Date of Birth:

SECTION 6 MEDICAL HISTORY (continued)

<p>6. Have you ever suffered a Sickness or Disease <u>NOT</u> 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. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)</i></p>	<p>Details:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>7. Have you ever had any of the following prescribed or advised which have <u>NOT</u> been taken or performed?</p> <p><i>If YES, please give full details. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnostic test or recommended treatment.)</i></p>	<p>a) Medication:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>b) Diagnostic tests:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<p>c) Surgery:</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COVERED INDIVIDUAL:

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 at Lloyd's, London 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 Underwriters at Lloyd's, London's rights or requirements, or to make or alter any contract or policy.
3. Underwriters at Lloyd's, London 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 Covered Individual 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 Underwriters at Lloyd's, London or their authorized representative; and
 - the first premium is received by Pro Financial Services, LLC within thirty (30) days from the date coverage is requested, unless approved otherwise in writing by Underwriters at Lloyd's, London or their authorized representative; and
 - all required and completed documents have been reviewed and the Application approved by Underwriters at Lloyd's, London or their authorized representative within sixty (60) days from the date all required and completed documents were received in the offices of Pro Financial Services, LLC

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 Underwriters at Lloyd's, London only if this application is accepted by Underwriters at Lloyd's, London. 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 Lloyd's, London 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 Covered Individual

Signed at _____ (City, State)

On this _____ day of _____, _____.

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 Underwriters at Lloyd's, London 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 Application, which we understand shall be attached to and constitute a part of the contract of insurance.

SIGNATURE OF CLUB OFFICIAL

Signed at _____ (City, State)

POSITION HELD

On this _____ day of _____, _____.

COVERED INDIVIDUAL:

Date of Birth:

DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Lloyd's, London 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.

Lloyd's, London 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.