PERSONAL ACCIDENT INSURANCE
(Accident & Sickness & Disease Policy)

PROOF OF PERMANENT TOTAL DISABLEMENT FORM

Issuance of this form does not imply admission of liability. The form must be filled out by the Covered Individual. Further information may be required during the investigation of this submission.

Please answer all questions completely and return form, together with the executed authorization to obtain information and executed Attending Physician's Statement, to Pro Financial Services, LLC, 500 West Madison Street, Suite 2660, Chicago, Illinois 60661. Incomplete forms will be returned for completion. Please use extra sheets, if necessary.

Covered Individual: _____

Covered Individual's Address: _____

Covered Individual's Telephone Number: _____

Profession: _____

Covered Individual's Date of Birth: _____

1. Is condition due to [ ] accident or [ ] sickness or [ ] disease (please check one).

   Please describe:

2. Date of accident or first treatment of sickness or disease.

3. Explain fully the bodily injury or sickness or disease sustained, and medical treatment received (use extra sheet if necessary):

4. Dates of Covered Individual's total disability:

   From _____ Through _____

5. Please list all physicians seen in the past five years, including current doctor:

6. Please list all hospitals in which Covered Individual was (is) confined:

7. Has Covered Individual participated in activities related to his sport since the accident or sickness? If yes, when and where:

8. Please list a possible beneficiary for the survivorship benefit:

I hereby declare the above particulars are true and complete in every respect. I hereby state and warrant that I have no intentions to ever again participate in the profession stated in the Schedule for the Policy.

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Covered Individual's Signature: _____ Dated: _____

Policy Number: _____

Please attach copy of all pertinent medical records and any other documents or materials to support submission. During the claim investigation, Underwriters require your full cooperation, which may include but is not limited to an independent medical examination and your assistance in acquiring pertinent records.

Please direct all inquiries and completed form, together with executed Attending Physician's Statement, to:

PRO FINANCIAL SERVICES, LLC
500 West Madison Street
Suite 2660
Chicago, Illinois 60661
Toll Free: 800-832-8000
Fax: 312-376-4668