APPLICATION

For Athlete's Disability Income Protection

Part I of II

Administrative Offices

PRO FINANCIAL SERVICES, LLC
500 W Madison Street,
Suite 2660
Chicago,
Illinois 60661

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

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 Everest Reinsurance 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 Everest Reinsurance Company or Pro Financial Services, LLC; 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 Everest Reinsurance Company or Pro Financial Services, LLC; and

- all documents have been reviewed and the Application approved by Everest Reinsurance Company or Pro Financial Services, LLC within sixty (60) days from the date coverage is requested.

Underwritten by
Everest Reinsurance Company

PROPOSED INSURED'S NAME: _____

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

PRO FINANCIAL SERVICES, LLC / EVEREST REINSURANCE COMPANY

ATHLETE'S DISABILITY INCOME PROTECTION

(All questions must be answered in ink or type. 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 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** ☐ M ☐ F

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: _____

20. Name and address of Policy Owner:

_____

_____

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

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

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

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

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: _____

_____

SECTION 4 MEDICAL HISTORY

1. Are you currently free of Injury, Sickness, Disease or Discomfort? *If NO, please give full details.*	Details: _____ _____ _____	☐ YES	☐ NO
2. Are you currently physically able to perform all of the duties required in your sport as stated in Section 1? *If NO, please give full details.*	Details: _____ _____ _____	☐ YES	☐ NO
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? *If YES, please give full details.*	Details: _____ _____ _____ _____	☐ YES	☐ NO

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 5 MEDICAL HISTORY

1. Have you, within the last twenty-four (24) months, taken any pain reducing or anti- inflammatory medication? *If YES, please give name of medication and reason taken.*	Name of Medication _____ Reason _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	☐ YES	☐ NO
2. During the last twelve (12) months, have you suffered any Injury, Sickness, Disease or Discomfort for which you have *NOT* sought: *If YES, please give full details.*	**a) Medical advice?** _____ _____	☐ YES	☐ NO
	b) Diagnosis? _____ _____	☐ YES	☐ NO
	c) Treatment? _____ _____	☐ YES	☐ NO
3. Have you been advised, or do you have reason to believe that you may need: *If YES, please give full details.*	**a) Medical treatment in the future?** _____ _____ _____ _____	☐ YES	☐ NO
	b) Surgical treatment in the future? _____ _____ _____ _____	☐ YES	☐ NO

SECTION 6 MEDICAL HISTORY

1. Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? *If YES, please give full details.*	**a) Head:** _____ _____	☐ YES	☐ NO
	b) Neck (cervical spine): _____ _____	☐ YES	☐ NO
	c) Right Shoulder: _____ _____	☐ YES	☐ NO
	d) Left Shoulder: _____ _____	☐ YES	☐ NO

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

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

SECTION 6 MEDICAL HISTORY (continued)

1. (continued) Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? *If YES, please give full details.*	**e) Chest (including ribs):** _____	☐ YES	☐ NO
	f) Upper Back (thoracic spine): _____	☐ YES	☐ NO
	g) Lower Back (lumbar spine including coccyx and tail bone): _____	☐ YES	☐ NO
	h) Pelvis/Hips (including groin – specify side): _____	☐ 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, fingers and thumb): _____	☐ YES	☐ NO
	m) Left Hand (including wrist, fingers and thumb): _____	☐ 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

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

SECTION 6 MEDICAL HISTORY (continued)

1. (continued) Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? *If YES, please give full details.*	**r) Right Lower Leg (including ankle and Achilles tendon):** _____	☐ YES	☐ NO
	s) Left Lower Leg (including ankle and Achilles tendon): _____	☐ YES	☐ NO
	t) Right Foot (including toes): _____	☐ YES	☐ NO
	u) Left Foot (including toes): _____	☐ YES	☐ NO
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.)? *If YES, please give full details.*	**a) Bones:** _____	☐ YES	☐ NO
	b) Joints: _____	☐ YES	☐ NO
	c) Muscles: _____	☐ YES	☐ NO
	d) Nerves: _____	☐ YES	☐ NO
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? *If YES, please give full details.*	Details: _____	☐ YES	☐ NO
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.)? *If YES, please give full details.*	Details: _____	☐ YES	☐ NO

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

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

SECTION 6 MEDICAL HISTORY (continued)

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? *If YES, please give full details.*	Family Member _____ Condition(s) _____	☐ YES	☐ NO
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? *If YES, please give full details.*	Details: _____	☐ YES	☐ NO
8. Have you ever had any of the following prescribed or advised which have NOT been taken or performed? *If YES, please give full details.*	**a) Medication:** _____	☐ YES	☐ NO
	b) Diagnostic tests: _____	☐ YES	☐ NO
	c) Surgery: _____	☐ YES	☐ NO

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

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

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.

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'S INITIALS **DATE**

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

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

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. Everest Reinsurance 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 Everest Reinsurance's rights or requirements, or to make or alter any contract or policy.
3. Everest Reinsurance 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 Everest Reinsurance Company or Pro Financial Services, LLC; 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 Everest Reinsurance Company or Pro Financial Services, LLC; and
   - all documents have been reviewed and the Application approved by Everest Reinsurance Company or Pro Financial Services, LLC within sixty (60) days from the date coverage is requested.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AUTHORIZATION TO OBTAIN INFORMATION

I understand that the insurance applied for will become effective on the date specified by Everest Reinsurance Company only if this Application is accepted by Everest Reinsurance 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 Everest Reinsurance 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___.

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 Everest Reinsurance 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. Everest Reinsurance 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.

Everest Reinsurance 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.