Certificate of Insured's Health

To the best of our knowledge and belief, we hereby certify that the Proposed Insured _____ is:

(Proposed Insuredôs Name)

Please circle one answer for each question listed below.

a) currently in good health?	Yes	No
b) currently free from injury?	Yes	No
c) healthy to participate in his/her respective sport without any restrictions?	Yes	No
d) has no reason to see a physician?	Yes	No

If the answer is ***NO*** to any of the above questions, please give dates and full details.

_____

_____

The statement below must be answered if a previous application has been submitted to Pro Financial Services, LLC

The _____ certify that the Proposed Insured has suffered no injuries or

(Name of Team)

sicknesses or diseases or had any surgeries since the teamôs last submission of the Application for Athleteôs Disability Income Protection dated _____ and Medical Examinerôs Report dated _____ provided to Pro Financial Services, LLC.

Please circle one answer.

Yes No

If the answer is ***NO*** to the above statement, please give dates and full details.

_____

_____

We understand that the insurance applied for will become effective on the date specified, provided that the Certification is approved.

_____ _____

Signature of Team Official/Physician Date

Please return completed form to:

Pro Financial Services, LLC
500 West Madison Street, Suite 2660
Chicago, Illinois 60661