MEDICAL EXAMINER'S REPORT

For Athlete's Disability Income Protection

Part II of II

Administrative Offices

PRO FINANCIAL SERVICES, LLC
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EVEREST

Underwritten by
Everest Reinsurance Company

PROPOSED INSURED'S NAME: ______________________________

PRO FINANCIAL SERVICES, LLC / EVEREST REINSURANCE 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 back page or attach your answers on a separate sheet.

ALL of the following sections must be completed by the Medical Examiner upon examination of the Proposed Insured.

SECTION 1 GENERAL INFORMATION

1. Name of Proposed Insured:

______________________ ______________________ ______________________
First Middle Last

2. Date of Birth: ______________________

3. Name of Team: ______________________

□ **Professional**
□ **Collegiate**
□ **Other (please state)**

4. Position: ______________________

5. Have you examined and/or treated the Proposed Insured in the past? □ YES for ________ (number of) years

□ NO

SECTION 2 MEDICAL HISTORY

Proposed Insured's:

1. Height ______________________ **2. Weight** ______________________

3. Blood Pressure ______________________ **4. Pulse** ______________________

5. Please check the appropriate box: *If any of the items are deemed abnormal please provide clinical definition of abnormality as well as details and results of any diagnostic tests performed.*

	Normal	Abnormal	Details
Head, Eyes, Ears, Nose or Throat:	□	□	______________________
Bones, Glands or Skin:	□	□	______________________
Lungs or other Respiratory Organs:	□	□	______________________
Heart, and the cardiovascular system including blood vessels:	□	□	______________________
EKG:	□	□	______________________
Stomach or other Abdominal Organs:	□	□	______________________
Genito-Urinary Organs (including prostate or hernias):	□	□	______________________

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.

Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 3 MEDICAL HISTORY

For Section 3, Questions 1 through 5:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

1. HEAD		□ YES □ NO	**Normal Exam Result?** □ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

2. NECK (cervical spine)		□ YES □ NO	**Normal Exam Result?** □ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

3. RIGHT SHOULDER		□ YES □ NO	**Normal Exam Result?** □ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

4. LEFT SHOULDER		□ YES □ NO	**Normal Exam Result?** □ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

5. CHEST (including ribs)		□ YES □ NO	**Normal Exam Result?** □ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

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

SECTION 3 MEDICAL HISTORY (continued)

For Section 3, Questions 6 through 10:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

6. UPPER BACK (thoracic spine)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

7. LOWER BACK (lumbar spine including coccyx & tail bone)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

8. PELVIS/HIPS (including groin - specify side)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

9. ABDOMEN (including stomach)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

10. RIGHT ARM (including elbow)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

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

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SECTION 3 MEDICAL HISTORY (continued)

For Section 3, Questions 11 through 15:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

11. LEFT ARM (including elbow)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

12. RIGHT HAND (including wrist, fingers and thumb)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

13. LEFT HAND (including wrist, fingers and thumb)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

14. RIGHT THIGH (including hamstring)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

15. LEFT THIGH (including hamstring)	□ YES □ NO	**Normal Exam Result?**	□ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

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

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SECTION 3 MEDICAL HISTORY (continued)

For Section 3, Questions 16 through 20 :

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

16. RIGHT KNEE		□ **YES** □ **NO**	**Normal Exam Result?** □ **YES** □ **NO**
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

17. LEFT KNEE		□ **YES** □ **NO**	**Normal Exam Result?** □ **YES** □ **NO**
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

18. RIGHT LOWER LEG (including ankle and Achilles tendon)		□ **YES** □ **NO**	**Normal Exam Result?** □ **YES** □ **NO**
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

19. LEFT LOWER LEG (including ankle and Achilles tendon)		□ **YES** □ **NO**	**Normal Exam Result?** □ **YES** □ **NO**
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

20. RIGHT FOOT (including toes)		□ **YES** □ **NO**	**Normal Exam Result?** □ **YES** □ **NO**
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

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 MEDICAL HISTORY (continued)

For Section 3, Question 21:

Please answer YES or NO as to whether or not the Proposed Insured has ever suffered any discomfort or injury or required treatment with respect to each body part.

Please give full details.

21. LEFT FOOT (including toes)		□ YES □ NO	**Normal Exam Result?** □ YES □ NO
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

SECTION 4

On completion of physical examination, please provide an overall impression with regard to Proposed Insured's ability to continue his or her career.

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Please indicate your relationship to the Proposed Insured by checking the appropriate box:

□ Personal Physician □ Team Physician □ Other (please specify): ______________________

I certify that I made this examination at ______ □ a.m. □ p.m. on the _____ day of ______________________, 20 _______

Examination made at: □ My Office □ Proposed Insured's Office □ Proposed Insured's Home □ Other ______________________

EXAMINERS SIGNATURE	**DATE**	**PROPOSED INSURED'S SIGNATURE**	**DATE**

______________________________ Examiner's Name (please print)

______________________________ Proposed Insured's Full Name (please print)

Examiner's Address: ______________________________

____

____

Examiner's Tel. 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.

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 Medical Examiner’s Report (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:____ Date of Birth:____/____/_____