Authorized Representative

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♦

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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:

_____

PRO FINANCIAL SERVICES, LLC/LLOYD'S, LONDON

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.

All questions must be answered in ink by the Covered Individual. 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** (such as how often per year, how long you have engaged in this activity, etc.).*	**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

COVERED INDIVIDUAL:	Date of Birth:

All questions must be answered in ink by the Covered Individual. Failure to answer all questions completely with full details will result in a delay in underwriting.

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

1. Are you currently free of Injury, Sickness, Disease or Discomfort? *If NO, please give **full details**. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)*	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**. (Include date(s) and reason.)*	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**. (Include number of events/games missed, date(s) and reason.)*	Details:	☐ YES	☐ NO

COVERED INDIVIDUAL: Date of Birth:

All questions must be answered in ink by the Covered Individual. 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**. (Include date(s), nature of Injury, Sickness, Disease or Discomfort.)*	**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**. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)*	**a) Head:**	☐ YES	☐ NO
	b) Neck (cervical spine):	☐ YES	☐ NO
	c) Right Shoulder:	☐ YES	☐ NO
	d) Left Shoulder:	☐ YES	☐ NO

COVERED INDIVIDUAL: 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**. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)*

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

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**. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)*	**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**. (Include date(s), nature of Injury, Sickness, Disease or Discomfort, diagnosis, treatment, duration and results.)*	**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**, including date(s).*	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** including date(s).*	Details:	☐ YES	☐ NO

All questions must be answered in ink by the Covered Individual. Failure to answer all questions completely with full details will result in a delay in underwriting.

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:	☐ 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

All questions must be answered in ink by the Covered Individual. Failure to answer all questions completely with full details will result in a delay in underwriting.

SECTION 6 MEDICAL HISTORY (continued)

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

All questions must be answered in ink by the Covered Individual. Failure to answer all questions completely with full details will result in a delay in underwriting.

Give complete details (**if not supplied elsewhere in the application**) 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 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.

COVERED INDIVIDUAL'S INITIALS **DATE**

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.