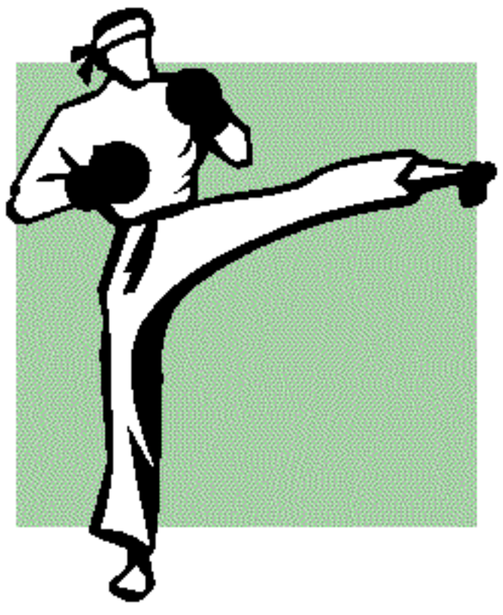
HIGH LIMIT PROFESSIONAL ATHLETE INSURANCE



Loss of Future Earnings, Contract Completion, Loss of Endorsements, Cost of Agents/Managers, College Draft Protection, High Limit Death & Dismemberment Benefits

Allen Financial Insurance Group

"The Nation's Leader In Sports Insurance"

Allen Financial Insurance Group

Section 1

Name of Proposed Insured _____

Address of Proposed Insured _____

_____

_____

Date of Birth _____ Sex: ☐ Male ☐ Female

Height _____ Weight _____

Proposed Insureds Occupation _____

Name of Team _____ Position _____

Do you have any other full or part-time employment? ☐ Yes ☐ No

If Yes, describe _____

_____

Employer _____

Employer Address _____

_____

Nature of Business _____

Date of Current Contact Expiration _____

Are you actively working in this occupation? ☐ Yes ☐ No

If No, describe _____

_____

How long have you been working as a professional in this occupation? _____

Other Past Employment: _____

_____

_____

Next Contact/Year Estimated Salary $_____

Last Contact/Year Salary Amount $_____

Section 2

Policy Owner: ☐ Insured ☐ Other

If Other, Name _____

Address _____

_____

_____

Description of Relationship to Insured Person _____

_____

_____

Section 3

Do you currently have or do you anticipate purchasing any other disability insurance? ☐ Yes ☐ No
If Yes, describe _____

_____

Have you during the last five years been insured for disability whether purchased by yourself or any other person on your behalf? ☐ Yes ☐ No
If Yes, describe _____

_____

Have you ever had a proposal for disability insurance declined or accepted with special conditions or exclusions imposed? ☐ Yes ☐ No
If Yes, describe _____

_____

Do you participate in winter sports other than skating or curling? ☐ Yes ☐ No
If Yes, describe _____

_____

Do you participate in water or underwater sports? ☐ Yes ☐ No
If Yes, describe _____

_____

Do you participate in rock climbing or mountaineering? ☐ Yes ☐ No
If Yes, describe _____

_____

Do you participate in motor sports or motorcycling? ☐ Yes ☐ No
If Yes, describe _____

_____

Do you participate in any activities that are excluded under your organization contract? ☐ Yes ☐ No
If Yes, describe _____

_____

Section 4

Are you at present free of injury, illness or discomfort? ☐ Yes ☐ No
If No, describe _____

Are you currently physically able to perform all of the duties required in your sport? ☐ Yes ☐ No
If No, describe _____

Have you missed any playing time during the last 24 months as a result of injury, illness, discomfort or for any other reason? ☐ Yes ☐ No
If Yes, describe _____

If you have visited your personal physician in the last 24 months, please provide dates and reasons for consultations.

Name of Personal Physician: _____

Address of Personal Physician: _____

Does your personal physician also act as the team or organization physician? ☐ Yes ☐ No

Have you consulted your team or organization physician in the last 24 months other than for routine examinations? ☐ Yes ☐ No
If Yes, describe _____

Have you within the last 24 months taken any pain reducing medication or anti-inflammatory medication? ☐ Yes ☐ No
If Yes, describe _____

Have you within the last 12 months suffered any injury, illness or discomfort for which you have not sought treatment for? ☐ Yes ☐ No
If Yes, describe _____

Have you been advised or do you have reason to believe that you will need to seek medical treatment in the future? ☐ Yes ☐ No
If Yes, describe _____

Have you been advised to have surgery which has not yet been undertaken? ☐ Yes ☐ No
Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? If Yes, please provide written details and use additional paper if necessary.

A. Head? ☐ Yes ☐ No

B. Neck (Cervical Spine)? ☐ Yes ☐ No

C. Right Shoulder? ☐ Yes ☐ No

D. Left Shoulder? ☐ Yes ☐ No

E. Chest (Including Ribs)? ☐ Yes ☐ No

F. Upper Back (Thoracic Spine)? ☐ Yes ☐ No

G. Lower Back (Lumbar Spine)? ☐ Yes ☐ No

H. Pelvis or Hips (Including Groin)? ☐ 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 and Fingers)? ☐ Yes ☐ No

M. Left Hand (Including Wrist and Finders)? ☐ 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

R. Right Lower Leg (Including Ankle)? ☐ Yes ☐ No

S. Left Lower Led (Including Ankle)? ☐ Yes ☐ No

T. Right Foot? ☐ Yes ☐ No

U. Left Foot? ☐ Yes ☐ No

Have you ever suffered any other injuries, discomfort or conditions to:

A. Bones? ☐ Yes ☐ No

B. Joints? ☐ Yes ☐ No

C. Muscles / Nerves? ☐ Yes ☐ No

Have you ever undergone surgery as the result of sickness, disease or a non-injury condition?
☐ Yes ☐ No

If Yes, describe _____

_____

Have you ever undergone hospitalization or treatment exceeding fourteen days as the result of sickness, disease, or a non-injury? ☐ Yes ☐ No
If Yes, describe _____
_____

Have you ever been advised that such surgery may be required in the future? ☐ Yes ☐ No
If Yes, describe _____
_____

Have you ever been prescribed any of the following which have not been undertaken?

Medication? ☐ Yes ☐ No
If Yes, describe
_____
_____

Diagnostic Tests? ☐ Yes ☐ No
If Yes, describe
_____
_____

Surgery? ☐ Yes ☐ No
If Yes, describe
_____
_____

Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any conditions of the following? If Yes, please describe.

Ears, Nose or Throat?	☐ Yes	☐ No	Heart or Chest?	☐ Yes	☐ No
Respiratory?	☐ Yes	☐ No	Blood Pressure?	☐ Yes	☐ No
Stomach?	☐ Yes	☐ No	Bladder?	☐ Yes	☐ No
Gout?	☐ Yes	☐ No	Hernia?	☐ Yes	☐ No
Cancer or Related Diseases?	☐ Yes	☐ No	Arthritis?	☐ Yes	☐ No
Liver or Kidneys?	☐ Yes	☐ No	Epilepsy?	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No	Mental Disorders?	☐ Yes	☐ No
Concussions?	☐ Yes	☐ No	Paralysis?	☐ Yes	☐ No
Thyroid Problem?	☐ Yes	☐ No	Partial Paralysis?	☐ Yes	☐ No

Have you ever suffered sickness not associated with any of the above, for which resulted in confinement of greater than seven days? ☐ Yes ☐ No
If Yes, describe _____
_____

Please give details of any family history of any of the conditions mentioned under the above previous two questions (ie Mother, Father, Brothers, Sisters).

Section 5

Coverage Requested:

☐ Loss of Future Earnings
☐ Loss of Endorsements
☐ College Draft Protection
☐ Contract Completion
☐ Cost of Agents/Managers
☐ High Limit Death & Dismemberment Benefits

IT IS UNDERSTOOF 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 will rely on this information in making their determination.
2. No agent, broker or medical examiner has the authority to waive the answers to any question, to determine insurability, to waive any of the Underwriters rights or requirements, or to make or alter any contact or policy.
3. The Underwriter 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 inception date of the proposed policy.

AUTHORIZATION TO OBTAIN INFORMATION

To all physician's, medical professionals, hospitals, clinics, other health care providers, insurers, employers, Medical Information Bureau (MIB), consumer reporting agencies, other insurance support organizations, and other person who have information about the proposed insured:

I authorize you to give Lloyds of London, its reinsurers, its agents, (a) all information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the proposed insured; and (b) any non-medical information, including an investigative consumer report, which the company believes it needs to perform the business functions described below.

The information obtained will be used to determine if the Proposed Insured is eligible for (a) the insurance requested; or (b) benefits under a policy which is in force. It will also be used for any other business purpose which relates to the insurance requested or the policy which is in force.

The form will be valid for 36 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

_____ _____

DATE SIGNATURE OF THE PROPOSED INSURED

The following declaration is ONLY to be completed where a team or organization 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 the Underwriters 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 contact of insurance.

_____ _____

DATE SIGNATURE OF TEAM / ORGANIZATION OFFICIAL

_____

TITLE

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