PROFESSIONAL ATHLETES APPLICATION

LONG FORM

Send completed application and exam to:
PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Boulevard Suite 215, Valencia, CA 91355
Email: piu@piu.org • Fax: (661) 254-0604 • Telephone (800) 345-8816

PROPOSED INSURED INFORMATION

Proposed Insured: First _____ Middle _____ Last_____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____

Gender: ☐ Male ☐ Female

Address: Number & Street _____

City _____ State _____ Zip Code _____

Sport: _____ Team Name: _____ Position: _____

Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

1. Are you presently applying, have in force, or are applying to reinstate any disability insurance other than this application? ☐ Yes ☐ No

Insurer	Date of Issue	Monthly Benefit	Lump Sum Benefit

2. Do you have other employment on a part time or full time basis? ☐ Yes ☐ No
3. Do you participate in winter sports, other than skating or curling? ☐ Yes ☐ No
4. Do you participate in water or underwater sports? ☐ Yes ☐ No
5. Do you participate in rock climbing or mountaineering? ☐ Yes ☐ No
6. Do you participate in motor sports or motorcycling? ☐ Yes ☐ No
7. Do you participate in any **OTHER** activities excluded by your club contract? ☐ Yes ☐ No

Details: _____

_____

_____

_____

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Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

MEDICAL INFORMATION

8. Do you currently have an injury, illness, or any discomfort? ☐ Yes ☐ No
   If "Yes" please provide details: _____

9. Do you have any physical limitation(s) that keep you from performing any duties of your sport? ☐ Yes ☐ No
   If "Yes" please provide details: _____

10. Have you missed any playing time during the last 24 months? ☐ Yes ☐ No
    If "Yes" please provide details: _____

11. Within the last 24 months have you taken any pain-reducing or anti-inflammatory medication? ☐ Yes ☐ No
    If "Yes" please provide details: _____

12. Have you had any diagnostic tests (X-rays, MRI, etc.) in the past 2 years? (List date(s), test(s) & results) ☐ Yes ☐ No
    If "Yes" please provide details: _____

13. Have you been advised, or do you have reason to believe that you may need medical treatment and/or surgery in the future? If "Yes" please provide details: ☐ Yes ☐ No
    _____

14. Do you have any hardware (such as pin(s), screw(s), rod(s), plates, etc.) remaining? ☐ Yes ☐ No
    If "Yes" please provide details: _____

15. Have you ever lost consciousness, been knocked out, or fainted? ☐ Yes ☐ No
    If "Yes" please provide details: _____

16. Do you have any knowledge or suspicion of bulged or herniated discs in your back and/or neck? ☐ Yes ☐ No
    If "Yes" please provide details: _____

17. Have you suffered any injury, sickness or discomfort for which you have **NOT** sought medical advice, diagnosis, or treatment? If "Yes" please provide details: ☐ Yes ☐ No
    _____

18. Have you ever undergone hospitalization/treatment exceeding 14 days or surgery as a result of sickness or disease or a non-injury condition? If "Yes" please provide details: ☐ Yes ☐ No
    _____

19. Have you consulted a physician in the last 24 months **other than for routine examination(s) or physical(s)?** ☐ Yes ☐ No
    If "Yes" please provide details: _____

20. Have you ever been prescribed medication, or recommended a diagnostic test, and/or surgery which have **NOT** been undertaken?: ☐ Yes ☐ No
    If "Yes" please provide details: _____

Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

21. Please answer the following questions and give details where appropriate. Have you ever injured, sprained, strained, dislocated, torn, suffered pain, tendonitis, discomfort, or had surgery for any of the following?:

a.	Head? (Including Concussion Or Unconsciousness)	❑ Yes ❑ No	
b.	Neck Or 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 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 & Digits)?	❑ Yes ❑ No	
m.	Left Hand (Including Wrist & Digits)?	❑ 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 And Achilles Tendon)?	❑ Yes ❑ No	
s.	Left Lower Leg (Including Ankle And Achilles Tendon)?	❑ Yes ❑ No	
t.	Right Foot?	❑ Yes ❑ No	
u.	Left Foot?	❑ Yes ❑ No	

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Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

22. Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any of the following conditions?:

a.	Gout?	☐ Yes ☐ No	_____
b.	Hernia(s)?	☐ Yes ☐ No	_____
c.	Concussion(s)?	☐ Yes ☐ No	_____
d.	Stomach or Bladder?	☐ Yes ☐ No	_____
e.	Dizziness or Fainting?	☐ Yes ☐ No	_____
f.	Rheumatism or Arthritis?	☐ Yes ☐ No	_____
g.	Ears, Eyes, Nose or Throat?	☐ Yes ☐ No	_____
h.	Blood Pressure or Diabetes?	☐ Yes ☐ No	_____
i.	Cancer and Related Diseases?	☐ Yes ☐ No	_____
j.	Liver, Kidneys, and/or Digestive Organs?	☐ Yes ☐ No	_____
k.	Heart, Chest, Circulatory System, and/or Respiratory System?	☐ Yes ☐ No	_____ _____
l.	Nervous System, Epilepsy, Mental Disorders, Seizures, or Convulsions?	☐ Yes ☐ No	_____ _____
m.	Paralysis whether complete or partial regardless of length of time and duration?	☐ Yes ☐ No	_____ _____

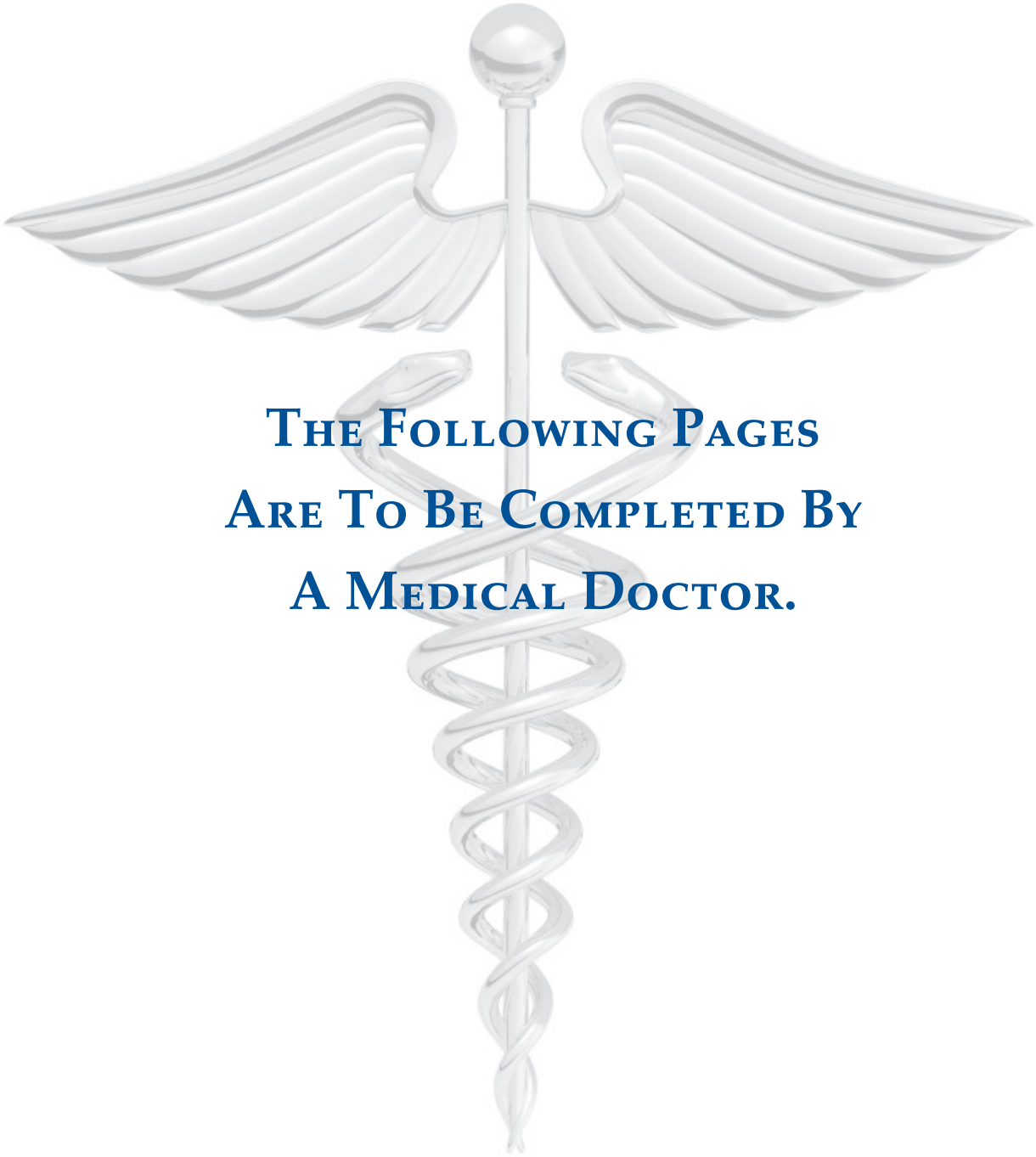
23. Have you ever suffered any sickness **NOT** associated with any of the above which resulted in confinement of greater than 7 days?: ☐ Yes ☐ No
If yes please provide details: _____
_____

24. Any family (mother, father, sibling(s)) history of any of the condition(s) mentioned under question #22 above? ☐ Yes ☐ No
If yes please provide details: _____
_____

It is understood and agreed as follows:

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 determinations. No agent, broker or medical examiner has authority to waive the answers to any questions, to determine insurability, to waive any of the underwriter's rights or requirements, or to make or alter any contract or policy. The underwriter has the right to require medical exams and tests to determine insurability. 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 policy. Underwriters do not bind themselves to accept this application for insurance, and reserve the right to decline and/or impose specific exclusions as a result of information disclosed herein. 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 30 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

Proposed Insured_____ Signature _____ Date_____
Please Print



The Following Pages Are To Be Completed By A Medical Doctor.

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MEDICAL DOCTOR'S REPORT FORM

Send completed application and exam to:

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ALL following sections are to be completed by Doctor on examination of player

Proposed Insured: First _____ Middle _____ Last_____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____

Sport: _____ Team Name: _____ Position: _____

1. Have you examined and/or treated this patient in the past?: ☐ Yes For _____ Years ☐ No
2. Has the Proposed Insured suffered discomfort, injury or treatment of any kind to any of the following? Doctor to query Proposed Inured. If answered "Yes" to any of the questions, please give details including dates (day/month/year).

a.	Head? (Including Concussion Or Unconsciousness)	☐ Yes ☐ No	_____
b.	Neck Or 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 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 & Digits)?	☐ Yes ☐ No	_____
m.	Left Hand (Including Wrist & Digits)?	☐ 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 And Achilles Tendon)?	☐ Yes ☐ No	_____ _____
s.	Left Lower Leg (Including Ankle And Achilles Tendon)?	☐ Yes ☐ No	_____
t.	Right Foot?	☐ Yes ☐ No	_____
u.	Left Foot?	☐ Yes ☐ No	_____

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MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: _____

If there is not sufficient space, please attach your answers on a separate sheet.

3. Doctor to examine Proposed Insured. If exam results were not normal, please describe in detail.

Exam Results

		Normal	Abnormal	
a.	Head? (Including Concussion Or Unconsciousness)	☐	☐	_____
b.	Neck Or Cervical Spine?	☐	☐	_____
c.	Right Shoulder?	☐	☐	_____
d.	Left Shoulder?	☐	☐	_____
e.	Chest (Including Ribs)?	☐	☐	_____
f.	Upper Back (Thoracic Spine)?	☐	☐	_____
g.	Lower Back (Lumbar Spine Including Coccyx And Tail Bone)?	☐	☐	_____
h.	Pelvis/Hips (Including Groin - Specify Side)?	☐	☐	_____
i.	Abdomen (Including Stomach)?	☐	☐	_____
j.	Right Arm (Including Elbow)?	☐	☐	_____
k.	Left Arm (Including Elbow)?	☐	☐	_____
l.	Right Hand (Including Wrist & Digits)?	☐	☐	_____
m.	Left Hand (Including Wrist & Digits)?	☐	☐	_____
n.	Right Thigh (Including Hamstring)?	☐	☐	_____
o.	Left Thigh (Including Hamstring)?	☐	☐	_____
p.	Right Knee?	☐	☐	_____
q.	Left Knee?	☐	☐	_____
r.	Right Lower Leg (Including Ankle And Achilles Tendon)?	☐	☐	_____
s.	Left Lower Leg (Including Ankle And Achilles Tendon)?	☐	☐	_____
t.	Right Foot?	☐	☐	_____
u.	Left Foot?	☐	☐	_____

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Proposed Insured: _____

If there is not sufficient space, please attach your answers on a separate sheet.

4. Please check the appropriate boxes:

	Normal	Abnormal	
Head	☐	☐	_____
Eyes, Ears, Nose & Throat	☐	☐	_____
Skin	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Abdomen	☐	☐	_____
Blood Pressure	☐	☐	_____
Pulse	☐	☐	_____

5. Has the Proposed Insured ever lost consciousness? ☐ Yes ☐ No
   If "Yes" please provide details: _____

6. Do you have any knowledge or suspicion of bulged or herniated disc(s) in the back and/or neck? ☐ Yes ☐ No
   If "Yes" please provide details: _____

7. Is the Proposed Insured currently taking medication(s)? ☐ Yes ☐ No
   If "Yes" please provide the medication and the reason being taken: _____

8. On completion of physical examination, please indicate overall impression with regard to player's ability to continue their career.

   _____

   _____

9. As a Physician, please state your relationship to the Proposed Insured, i.e., Personal Physician, Team Physician, etc?

   _____

   _____

Proposed Insureds Signature _____ Date _____

Physician Information

Physicians Name: First _____ Middle _____ Last _____

Address: Number & Street _____

City _____ State _____ Zip Code _____

Phone Number: _____ Fax: _____ Email: _____

Physician's Signature: _____ Date _____

Authorization to Release Personal Information

In Compliance with HIPAA & Financial Privacy Regulation

I, the proposed insured, authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/representative including, but not limited to: Secure Image Solutions, for the purpose of insurance underwriting or claims administration.

For purposes of this authorization, medical records shall include all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, HIV Tests/Test Results, and any other pertinent medical information.

I understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above. Additionally, it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to Petersen International Underwriters.

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization. This Authorization will expire 2 years after the date that I have signed this Authorization.

Printed Name of Proposed Insured	Date of Birth
Signature of Proposed Insured	Date
*Printed Name of Legal Representative (if other than Proposed Insured)	Relationship to the Proposed Insured
Signature of Legal Representative (if other than Proposed Insured)	Date

**If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.*

Please Email, Fax or Mail This Form To:

PETERSEN
INTERNATIONAL UNDERWRITERS
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