PROFESSIONAL ATHLETES APPLICATION

LONG FORM AND MEDICAL EXAM

Offered Exclusively by:
eGlobalHealth Insurers Agency, LLC
Broker # 26356
Derek Patterson, Broker/Agent
www.GlobalRiskBroker.com
info@GlobalRiskBroker.com
Direct: 417-882-1413
Fax: 417-459-4623

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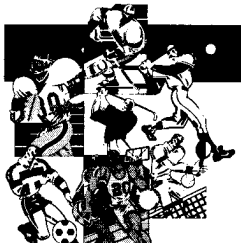
PETERSEN INTERNATIONAL UNDERWRITERS
Lloyd's Correspondents
23929 Valencia Boulevard Suite 215 Valencia California 91355
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604
E-Mail: piu@piu.org Website: www.piu.org



PROFESSIONAL ATHLETES APPLICATION

Proposal Form
Send completed application and exam to:

LONG FORM

eGlobalHealth Insurers Agency, LLC

info@GlobalRiskBroker.com Direct: 417-882-1413 Fax: 417-459-4623

(all questions must be completed in ink)

Proposed insured

1) Name in full: _____

2) Residential Address: _____
STREET CITY, STATE ZIP

_____

3) Birthdate: _____ 4) ❒ FEMALE ❒ MALE

5) Height: _____ 6) Weight: _____

7) I currently participate in (sport) _____

As a... ❒ PROFESSIONAL ❒ COLLEGIATE ❒ OTHER (please state) _____

8) Name of Team: _____ 9) Position: _____

10) Do you have other employment (full or part-time)? ❒YES ❒ NO

if "YES," please describe: _____

11) Are you presently applying, have in force, or are applying to reinstate any disability ❒ YES ❒ NO
insurance other than this application? (If yes, please list below)

Insurer	Date of Issue	Monthly Benefit	Lump Sum Benefit

12) Do you participate in any of the following?

a) Winter sports, other than skating or curling ❒YES ❒ NO If "YES," please give details...

_____

_____

b) Water or underwater sports ❒ YES ❒ NO if 'YES," please give details...

_____

_____

c) Rock climbing or mountaineering ❒ YES ❒ NO If "YES," please give details...

_____

_____

_____

_____

d) Motor sports or motorcycling ❒YES ❒ NO If "YES," please give details...

_____

_____

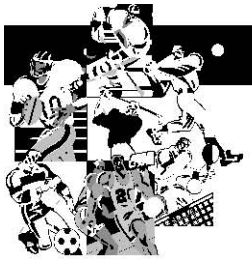
_____

_____

e) Any other activities **excluded** by your club contract ❒ YES ❒ NO If 'YES," please give details

_____

_____



PROFESSIONAL ATHLETES APPLICATION

Proposed Insured: _____

Wherever "**YES**" or "**NO**" answers require full details, these should be given in the space provided. However, if there is not sufficient space, please attach your answers on a separate sheet.

1) Are you at present free of injury, illness or discomfort? If "NO," please give details. ❑ YES ❑ NO

_____

_____

2) Are you currently physically able to perform all the duties required in your sport as stated in the Proposal Form? If "NO," please give details. ❑ YES ❑ NO

_____

_____

3) Have you missed any playing time during the last 24 months as a result of injury, illness, discomfort or for any other reason? If "YES," please give details. ❑ YES ❑ NO

_____

_____

4) Do you have a personal physician other than your team Doctor? If yes, give details below. ❑ YES ❑ NO

Name _____

Address _____

If you have consulted your personal physician in the last 24 months, please give dates and reason for consultation.

_____

_____

5) Have you consulted your team physician or any other physician in the last 24 months **other than for routine examination or physical?** If "YES," please give details including name and address of physician. ❑ YES ❑ NO

Physician's Name: _____

Physician's Address: _____

Details: _____

6) Have you within the last 24 months taken any pain-reducing or anti-inflammatory medication? ❑ YES ❑ NO

If "YES," please give details including names(s) of medication(s). _____

_____

7) During the last 12 months have you suffered any injury, sickness or discomfort for which you have NOT sought the following?

If "YES," please give details.

a. medical advice? ❑ YES ❑ NO _____

b. diagnosis? ❑ YES ❑ NO _____

c. treatment? ❑ YES ❑ NO _____

8 Have you been advised, or do you have reason to believe that you may need medical treatment in the future? ❑YES ❑ NO

If "YES," please give details. _____

9) Have you ever been advised to have surgery and have not done so? If "YES," please give details. ❑ YES ❑ NO

10) Do you have any hardware remaining? Such as pins, screws, rod(s), plates, (etc.) ❑ YES ❑ NO

Details _____

_____

PROFESSIONAL ATHLETES APPLICATION

Personal Medical History Form

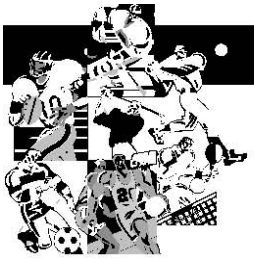
Proposed Insured: _____

Wherever "**YES**" or "**NO**" answers require full details, these should be given in the space provided. However, if there is not sufficient space, please attach your answers on a separate sheet.

11) Please answer the following questions and give details where appropriate. Have you ever injured or suffered pain or discomfort or had surgery for any of the following:

a)	HEAD?	❑ YES ❑ NO	**l)**	RIGHT HAND (including wrist and digits)?	❑ YES ❑ NO
b)	NECK (cervical spine)?	❑ YES ❑ NO	**m)**	LEFT HAND (including wrist and digits)?	❑ YES ❑ NO
c)	RIGHT SHOULDER?	❑ YES ❑ NO	**n)**	RIGHT THIGH (including hamstring)?	❑ YES ❑ NO
d)	LEFT SHOULDER?	❑ YES ❑ NO	**o)**	LEFT THIGH (including hamstring)?	❑ YES ❑ NO
e)	CHEST (including ribs)?	❑ YES ❑ NO	**p)**	RIGHT KNEE?	❑ YES ❑ NO
f)	UPPER BACK (Thoracic Spine)?	❑ YES ❑ NO	**q)**	LEFT KNEE?	❑ YES ❑ NO
g)	LOWER BACK (Lumbar Spine including Coccyx and tail bone)?	❑ YES ❑ NO	**r)**	RIGHT LOWER LEG (including ankle and Achilles Tendon)?	❑ YES ❑ NO
h)	PELVIS/HIPS (including groin–specify side)?	❑ YES ❑ NO	**s)**	LEFT LOWER LEG (including ankle and Achilles Tendon)?	❑ YES ❑ NO
i)	ABDOMEN (including stomach)?	❑ YES ❑ NO	**t)**	RIGHT FOOT?	❑ YES ❑ NO
j)	RIGHT ARM (including elbow)?	❑ YES ❑ NO	**u)**	LEFT FOOT?	❑ YES ❑ NO
k)	LEFT ARM (including elbow)?	❑ YES ❑ NO			

Please give details including dates (day/month/year) to any question above answered "YES". _____



PROFESSIONAL ATHLETES APPLICATION

Proposed Insured: _____

Wherever "**YES**" or "**NO**" answers require full details, these should be given in the space provided. However, if there is not sufficient space, please attach your answers on a separate sheet.

12) Have you suffered any other injuries, discomfort or conditions related to:

a) BONES? ❑ YES ❑ NO
b) JOINTS? ❑ YES ❑ NO
c) MUSCLES? ❑ YES ❑ NO
d) NERVES? ❑ YES ❑ NO
e) E.G. SPRAINS, STRAINS, DISLOCATIONS, TENDONITIS, TEARS, etc. not listed previously? ❑ YES ❑ NO

Please give details including dates (day/month/year) to any question above answered "YES". _____

13) Have you had any diagnostic tests (X-rays, MRI, etc.) in the past 2 years? (List date(s), test(s) & results) ❑ YES ❑ NO

14) Have you ever undergone surgery as a result of sickness or disease or a non-injury condition? ❑ YES ❑ NO

If "YES," please give details. _____

15) Have you ever undergone hospitalization or treatment exceeding 14 days as a result of sickness ❑ YES ❑ NO

or disease or a non-injury condition? If "YES," please give details. _____

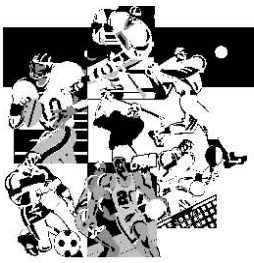
16) Have you ever been advised that such surgery may be required in the future? ❑ YES ❑ NO

If "YES," please give details. _____

17) Have you ever been prescribed any of the following which have **NOT** been undertaken?:

If "YES," please give details including dates (day/month/year).

a) MEDICATION? ❑ YES ❑ NO _____
b) DIAGNOSTIC TESTS? ❑ YES ❑ NO _____
c) SURGERY? ❑ YES ❑ NO _____



PROFESSIONAL ATHLETES APPLICATION

Personal Medical History Form

Proposed Insured: _____

Wherever "**YES**" or "**NO**" answers require full details, these should be given in the space provided. However, if there is not sufficient space, please attach your answers on a separate sheet.

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

a) EARS, EYES, NOSE or THROAT?	❑ YES ❑ NO	h) CANCER and related diseases	❑ YES ❑ NO
b) HEART, CHEST CIRCULATORY SYSTEM and RESPIRATORY SYSTEM?	❑ YES ❑ NO	I) RHEUMATISM or ARTHRITIS?	❑ YES ❑ NO
c) BLOOD PRESSURE or DIABETES?	❑ YES ❑ NO	j) LIVER, KIDNEYS AND DIGESTIVE ORGANS	❑ YES ❑ NO
d) STOMACH or BLADDER?	❑ YES ❑ NO	k) NERVOUS SYSTEM, EPILEPSY OR MENTAL DISORDERS, or SEIZURES or CONVULSIONS	❑ YES ❑ NO
e) DIZZINESS or FAINTING?	❑ YES ❑ NO	l) CONCUSSIONS?	❑ YES ❑ NO
f) GOUT	❑ YES ❑ NO	m) PARALYSIS whether complete or partial regardless of length of time and duration?	❑ YES ❑ NO
g) HERNIAS?	❑ YES ❑ NO		

Please give details including dates (day/month/year) to any question above answered "YES". _____

19) Have you ever suffered any sickness not associated with any of the above which resulted in confinement of greater than 7 days? If "YES," please give details. ❑ YES ❑ NO _____

20) Any family history of any of the conditions mentioned under Question 18 above, and relationship. (i.e. Mother, Father, Brother, etc.) ❑ YES ❑ NO _____

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 will rely on this information in making their determinations.

2) 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.

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 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.

Authorization to obtain information: To all physicians; medical professionals; hospitals; clinics; other health care providers; insurers; employers; Medical Information Bureau (MIB); consumer reporting agencies; other insurance support organizations; and other persons who have information about the Proposed Insured: I authorize you to give the Company, 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 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** _____

The following pages
are to be completed
by a medical doctor.

MEDICAL EXAM PAGES 1, 2 & 3

PROFESSIONAL ATHLETES MEDICAL EXAM

MEDICAL DOCTOR'S REPORT FORM

Send complete exam to:

PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Boulevard Suite 215 Valencia, California 91355

Telephone (661) 254 -0604 (800) 345-8816 Facsimile (661) 254-0604

All questions must be answered in ink

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

1) **Proposed Insured:** _____
FIRST MIDDLE LAST

2) **Date of Birth:** _____

3) **Name of Team:** _____

❒ PROFESSIONAL ❒COLLEGE ❒ OTHER (please specify) _____

4) **Position:** _____

5) **Have you examined and or treated this patient in the past?** ❒ YES FOR _____ YEARS ❒NO
NUMBER OF

6) **Has the proposed insured suffered discomfort, injury or required treatment of any kind to any of the following? Doctor to query Proposed Insured. 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 (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, 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	_____
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	_____

PROFESSIONAL ATHLETES MEDICAL EXAM

MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: _____

7) ***Doctor to examine Proposed Insured. If exam results were not normal, please describe in detail.***
If more space is required, attach a separate sheet.

Exam Results

		NORMAL	ABNORMAL	
a)	HEAD (including concussion or unconsciousness)	❒	❒	_____
b)	NECK (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, fingers and thumb)	❒	❒	_____
m)	LEFT HAND (including wrist, fingers and thumb)	❒	❒	_____
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	❒	❒	_____

PROFESSIONAL ATHLETES MEDICAL EXAM

MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: _____

8) Height: _____ **9)** Weight: _____

10) Blood Pressure _____ **11)** Pulse: _____

12) Please check the appropriate boxes

	Normal	Abnormal	Comments
Head	❒	❒	
Eyes, Ears, Nose & Throat	❒	❒	
Skin	❒	❒	
Lungs	❒	❒	
Heart	❒	❒	
Abdomen	❒	❒	

13) Current medication(s) and reason(s) taken _____

14) On completion of physical examination, overall impression with regard to player's ability to continue their career.

_____

_____

_____

_____

_____

15) As a Physician, please state your relationship to the proposed insured, i.e., Personal Physician, Team Physician, etc?

_____

_____

_____

I certify that I made this examination at _____ ❑ a.m. ❑ p.m. on the _____ day of _____, 20_____.

Examination made at ❑ my office ❑ individual's office ❑ individual's home ❑ other _____

_____ _____

PHYSICIAN'S SIGNATURE **APPLICANT'S SIGNATURE**

_____ _____

PHYSICIAN'S FULL NAME (PLEASE PRINT) **APPLICANT'S FULL NAME (PLEASE PRINT)**

_____ _____

PHYSICIAN'S ADDRESS **EXAMINER'S TELEPHONE**

_____ _____

EXAMINER'S FAX

PETERSEN INTERNATIONAL UNDERWRITERS, INC.

23929 Valencia Boulevard, Suite 215, Valencia, California 91355
(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604
Website: http://www.piu.org E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE PERSONAL INFORMATION
HIPAA Compliant

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to provide to Petersen International Underwriters, Inc., or to any agency authorized by Petersen International Underwriters, Inc. to collect any and all such information by means of U.S. Post, fax or e-mail.

I AUTHORIZE Petersen International Underwriters, Inc. to communicate with me/us or our representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, or additional coverages from Petersen International Underwriters, Inc.

I UNDERSTAND the purpose of this Authorization is to allow Petersen International Underwriters, Inc., to determine eligibility for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by Petersen International Underwriters, Inc., to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I UNDERSTAND that I may revoke this Authorization, except to the extent that Petersen International Underwriters, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to Petersen International Underwriters, Inc. Any such revocation may also have an impact upon my underwriting or claims processing.

I UNDERSTAND that I can obtain a complete copy of Petersen International Underwriters, Inc. Privacy Policy either on Petersen International Underwriters, Inc. website or by contacting them directly and asking for a copy.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signed this _____ day of _____, 20_____

_____
Signature of Proposed Insured

_____
Name of Proposed Insured

Petersen International Underwriters
Privacy Policy Statement

Petersen International Underwriters

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

Information We Collect

We collect non-public information about you from numerous sources including, but not limited to:

a) Information we receive from you on applications and other forms;
b) Information about your transactions with our affiliates, others or us;
c) Information we receive from consumer-reporting agencies; and
d) Financial and medical sources.

Information We Disclose

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

Confidentiality and Security

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

Contacting Us

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: piu@piu.org