SUTTON
SPECIAL RISK

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Sports Application Form and Medical Examiner's Report

PART 1 - APPLICATION FORM.

This section constitutes pages 1 - 4.
The Applicant must answer all questions in ink. Make sure to sign and date the Application.

Section 1: Applicant Information

Full Name _____

Address _____

_____

Birth Date _____ Weight _____ Height _____ Sex: Male ◯ Female ◯
Month Day Year

Sport _____ Professional _____ Other _____

Name of Team _____ Position _____

Section 2: Health Questionnaire - Circle Yes or No. Please provide additional information and dates in the space below.

1. Are you currently free of injury, illness or discomfort? If No, explain below.	Yes	No
2. Are you currently physically able to perform all of the duties required in your sport as stated in Section 1 of the Application Form? If No, explain below.	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, explain below.	Yes	No
4. Do you require any type of knee brace while playing or practising? If Yes, explain below.	Yes	No
5. Have you consulted your team physician or any other physician in the last 24 months other than for routine examination or team physical? If Yes, explain below.	Yes	No
6. Have you within the last 24 months, taken any pain reducing or anti-inflammatory medication? If Yes, explain below, including name of drug, dates taken, and reason.	Yes	No
7. During the last 12 months, have you suffered any injury, sickness or discomfort for which you have not sought medical advice? If Yes, explain below.	Yes	No
8. Have you been advised or do you have reason to believe that you may need medical treatment in the future? If Yes, explain below.	Yes	No
9. Have you ever been advised to have treatment which has not been undertaken? If Yes, explain below.	Yes	No

Additional Information (please indicate question number for which you are providing details):

_____

_____

_____

Section 3: Circle Yes or No. If Yes, please give details. Additional space is provided below.

Do you engage in any of the following activities, or other similar activities, which may be considered hazardous?

1. Piloting an aircraft ◯Yes ◯No _____
2. Skydiving or hang-gliding ◯Yes ◯No _____
3. Water or underwater sports ◯Yes ◯No _____
4. Winter sports, other than skating or curling ◯Yes ◯No _____
5. Motor sports or motorcycling ◯Yes ◯No _____
6. Rock climbing or mountaineering ◯Yes ◯No _____
7. Other activities excluded by your club contract ◯Yes ◯No _____

Details: _____

Section 4: Circle Yes or No. If Yes, please give details. Additional space is provided below.

Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? If Yes, give details including dates.

1. Head ◯Yes ◯No _____
2. Neck (Cervical Spine) ◯Yes ◯No _____
3. Right Shoulder (including Clavicle & Shoulder Blade) ◯Yes ◯No _____
4. Left Shoulder (including Clavicle & Shoulder Blade) ◯Yes ◯No _____
5. Chest (including ribs, sternum & diaphragm) ◯Yes ◯No _____
6. Upper Back ◯Yes ◯No _____
7. Lower Back (including tail bone) ◯Yes ◯No _____
8. Right Hip ◯Yes ◯No _____
9. Left Hip ◯Yes ◯No _____
10. Groin? Specify side. ◯Yes ◯No _____
11. Abdominal Muscles ◯Yes ◯No _____
12. Right Arm (including elbow) ◯Yes ◯No _____
13. Left Arm (including elbow) ◯Yes ◯No _____
14. Right Hand (including wrist/fingers) ◯Yes ◯No _____
15. Left Hand (including wrist/fingers) ◯Yes ◯No _____
16. Right Thigh (including hamstring) ◯Yes ◯No _____
17. Left Thigh (including hamstring) ◯Yes ◯No _____
18. Right Knee ◯Yes ◯No _____
19. Left Knee ◯Yes ◯No _____
20. Right Lower Leg (including ankle & Achilles tendon) ◯Yes ◯No _____
21. Left Lower Leg (including ankle & Achilles tendon) ◯Yes ◯No _____
22. Right Foot (including toes) ◯Yes ◯No _____
23. Left Foot (including toes) ◯Yes ◯No _____
24. Have you suffered any other injuries, discomfort or conditions to:
    a. Bones ◯Yes ◯No _____
    b. Joints ◯Yes ◯No _____
    c. Muscles ◯Yes ◯No _____
    d. Nerves ◯Yes ◯No _____

Additional Information (please indicate question number for which you are providing details):

_____

_____

_____

Section 5: Circle Yes or No. If Yes, please give details including dates. Additional space is provided below.

Within the last 10 years, have you ever shown indications of, suffered from, been treated for, or been prescribed treatment for any condition of the following:

1. Cardiac such as heart murmur, heart attack, angina, chest pain, high or low blood pressure, or any other disease of the heart or blood vessels? Yes No
2. Respiratory system such as asthma, chronic bronchitis, or emphysema, shortness of breath, pneumonia or any other respiratory disease? Yes No
3. Digestive such as ulcer, colitis, bleeding, gallbladder or liver disease or any other disorder of the stomach, intestines or rectum? Yes No
4. Nervous system such as paralysis, anxiety, seizures, depression or any other mental disease? Yes No
5. Endocrine such as diabetes, thyroid, or any other glandular disease? Yes No
6. Any disease of the blood? Yes No
7. Skin disease, cancer, cyst or tumor? Yes No
8. Rheumatism, arthritis, ruptured disc, or any disease injury or deformity of the spine, joints, bones or muscles? Yes No
9. Any disease of the kidneys, bladder, prostate or reproductive organs? Yes No
10. Any disease of the eyes, ears, nose or throat? Yes No
11. Paralysis whether complete or partial, regardless of length of time or duration? Yes No

Additional Information (please indicate question number for which you are providing details): _____

Section 6: Concussions

1. Have you ever had a concussion? Yes No If Yes, please answer questions 2-5 In this section in full detail.

2. Number of incidents and dates: _____

3. Did you lose consciousness in any of the incidents? _____

4. What degree of severity were they? _____

5. How much time in total did you miss after each incident? (include number of games missed)

Section 7: Circle Yes or No. If Yes, please give details. Additional space is provided below.

1. Are you now, or have you ever been treated for substance or alcohol abuse? Yes No
2. Have you ever used marijuana, mood-altering drugs, narcotics, cocaine, heroin, barbituates, LSD or amphetamines? Yes No

PLEASE READ CAREFULLY

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. The Insurer will rely on this information in making their determinations.
2. No agent, broker or medical examiner has authority to waive the answers to any question, to determine insurability, to waive any of the Insurer's rights or requirements, or to make or alter any contract or policy.
3. The Insurer 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 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 Insurer, 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 any 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.

I understand that I may withdraw my consent at any time, in writing, subject to legal or contractual restrictions and reasonable notice.

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.

_____ _____

month day year Signature of Proposed Insured

_____

Name of Proposed Insured (PLEASE PRINT)

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 of 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 Insurer 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 Contract of Insurance.

_____ _____ _____

Signature of Team Official month day year Position Held

Part 2 - Medical Examiner's Report

This section constitutes pages 5 - 9. All questions must be answered in ink.

All following sections to be completed by a Medical Examiner on examination of player.

Name of Proposed Insured: _____

Have you examined and/or treated this patient in the past?	☐ Yes, for _____ years ☐ No

Current Vital Signs on this Examination

Height _____ Weight _____

Blood Pressure _____ Pulse _____

Please check the appropriate box.

	Normal	Abnormal	Comments:
Head, Eyes, Ears, Nose & Throat	☐	☐	
Skin	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
EKG	☐	☐	
Abdomen	☐	☐	
Genitalia	☐	☐	
Respiratory	☐	☐	
Circulatory	☐	☐	

Has the Proposed Insured suffered discomfort, injury or required treatment to any of the following:		**Upon examination, were there any abnormalities identified?**	

1. HEAD	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality) Concussion details, if applicable.		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

2. NECK (Cervical Spine)	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

3. RIGHT SHOULDER, CLAVICLE, SCAPULA	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

4. LEFT SHOULDER, CLAVICLE, SCAPULA	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

5. CHEST (including Ribs, Sternum, Diaphragm)	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

6. UPPER BACK (Thoracic Spine)	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

7. LOWER BACK (Lumbar spine incl. Coccyx and Sacral Spine)	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

8. RIGHT HIP	YES	NO		YES	NO
DATES	DETAILS (discomfort, injury, or abnormality)		DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS	

Has the Proposed Insured suffered discomfort, injury or required treatment to any of the following:		**Upon examination, were there any abnormalities identified?**	

9. LEFT HIP	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

10. RIGHT GROIN	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

11. LEFT GROIN	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

12. ABDOMINAL MUSCLES	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

13. RIGHT ARM (including elbow)	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

14. LEFT ARM (including elbow)	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

15. RIGHT HAND (including wrist/fingers)	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

16. LEFT HAND (including wrist/fingers)	YES NO		YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

Has the Proposed Insured suffered discomfort, injury or required treatment to any of the following:		**Upon examination, were there any abnormalities identified?**

17. RIGHT THIGH (including hamstring) YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

18. LEFT THIGH (including hamstring) YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

19. RIGHT KNEE YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

20. LEFT KNEE YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

21. RIGHT LOWER LEG (including ankle and achilles tendon) YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

22. LEFT LOWER LEG (including ankle and achilles tendon) YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

23. RIGHT FOOT (including toes) YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

24. LEFT FOOT (including toes) YES NO			YES NO
DATES	DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT	CURRENT & FUTURE PROGNOSIS

On completion of physical examination, please provide your overall impression with regard to player's ability to continue his career:

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 on _____
month day year

EXAMINER'S SIGNATURE

EXAMINER'S NAME (please print)

EXAMINER'S ADDRESS

TELEPHONE NUMBER _____

FAX NUMBER _____

E-MAIL _____

ANY ADDITIONAL COMMENTS: