Application Form

prosport cover
professional athlete insurance

Section 1: Policy Owner Information

Full Name

Address

Phone Mobile

Email

Relationship to insured person

Do you own any other insuance policy covering the insured person? Yes No. If yes, provide details below:

Complete below only if you currently own a policy on the insured person

Insured value Policy expiry date

Insurance company name

Have you made any claims against this policy previously? Yes No. If yes, provide details below:

Section 2: Insured Person Information

Full Name

Address

Birth Date Weight Height Male Female

Sport Name of Team

Position played Are you a Full Time Professional Athlete? Yes No

If no, provide full details of your other occupation activities.

How long is your contract period? Contract value for the full term of your contract? $

When did that contract commence?

Do you receive any endorsements/ sponsorships in addition to the above? Yes No

If yes, what is the annual value of the additional income received? $

Section 3: Coverage requested

- ☐ Loss of Future Earnings
- ☐ Loss of Endorsements
- ☐ Contract Deferment/Draft Protection
- ☐ Cost of Agents/Managers Protection

Sum insured _____

☐ High Limit Death, TPD & Dismemberment Benefits — Sum insured _____

☐ Contract Completion (Professional Clubs Only) — Sum insured _____

☐ Death and Disgrace — Sum insured _____

☐ Player Catastrophe — Sum insured (aggregate player value) _____

Section 4: Health Questionnaire

Select 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 2 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. 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
8. 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 5

Select 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 6

Select Yes or No. If Yes, please give details. Additional space is provided on the following page

Have you ever 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 and Shoulder Blade)	☐ Yes	☐ No	
4. Left Shoulder (including Clavicle and 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	

Section 6 (continued)

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 7

Select Yes or No. If Yes, please give details. Additional space is provided on the following page.

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

Section 7 (continued)

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 8: Concussions

1. Number of incidents and dates:

2. Did you lose consciousness in any of the incidents?

3. What grade or degree of severity were they?

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

Section 9

Select 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

3. Have you ever been convicted of any criminal offence? ☐ 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. Underwriters will rely on this information in making their determination.
2. The Underwriter has the right to require medical exams and tests to determine insurability.
3. 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.

Date _____ Signature of insured person _____

The following declaration is ONLY to be completed where a team or organisation 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/ organiser official _____

Title _____

Please save and email your completed form to sales@prosportcover.com.au

prosport cover
professional athlete insurance

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