INTERNATIONAL
SPECIALTY INSURANCE, INC

HELPING PROTECT WHAT YOU'VE ACHIEVED

QUESTIONS?
800-849-0474

INSTRUCTIONS: Print in black and initial all changes. Answer all questions in their entirety. Any unanswered questions will delay the processing "N/A" or "None" are unsatisfactory answers and will not be accepted.

Motorsport Disability Insurance Application

Every question must be answered fully and correctly by the Person to be Insured

The Person to be Insured may need to consult his Doctor to provide all material information Insurers will require. Before any question is answered please carefully read the Declaration at the end of this proposal, which must be signed and dated by the Proposer, and the Person to be Insured. Please disclose the following information (Please note that non-disclosure of information might jeopardize any claim in the future):

- Current injuries with date of injury, diagnosis, future prognosis and expected return to fitness.
- Any significant injuries during the last ten years. Significant injuries are defined as injuries that kept the Person to be Insured from training or racing for more than 14 consecutive days.
- Any recurring injuries during the last five years, which can be defined as the same type of injury to the same location.
- Date of injury, date of full fitness, diagnosis, and treatment received, details of surgery and current condition.
- Future medical treatment or surgery for an existing or previous injury.
- Any other injury or illness that you feel might lead to disablement of the Person to be Insured in the future.
- Information on osteoarthritis, arthritis or any other degenerative process of the joints, bones, muscles, tendons or ligaments.
- Pre-existing Conditions.

Further medical information may be required by the Insurer on specific injuries or sickness. Medical file reviews will be carried out to ensure that all the necessary information has been supplied. If there is not sufficient space, please attach answers on a separate sheet.

The Proposer

FIRST NAME | M.I. | LAST NAME

ADDRESS

CITY | STATE | ZIP CODE

The Person to be Insured

FIRST NAME | M.I. | LAST NAME

PLACE OF BIRTH CITY | STATE | COUNTRY

SOCIAL SECURITY NO.

GENDER: ☐ MALE ☐ FEMALE

WEIGHT: HEIGHT:

Which motor racing series will you be competing in over the next 12 months?

What is your gross contracted salary excluding bonuses this year:

TEAM

What is your gross contracted salary excluding bonuses next year:

CONTRACT EXPIRY DATE:

Is any portion of your contracted salary payable to you while you are unable to work due to injury or sickness? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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MEDICAL DETAILS

In the event that any question has not been answered satisfactorily, underwriters reserve the right to either return this form to the applicant for the answers to be completed, or to impose any restriction, or pre-exisiting conditions exclusion on the coverage required until such time as the application has been satisfactorily completed.

This section must be completed by the Person to be Insured.

1a. Does the sanctioning body in whose events you participate require annual medical exams? ☐ YES ☐ NO

IF YES, PLEASE ADVISE WHEN WAS THE LAST EXAM:

1b. Did the sanctioning body issue you a license or permission without restrictions? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE FULL DETAILS:

2. Are you currently free of injury, sickness, disease or discomfort and able to perform all of the duties required in your sport? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE FULL DETAILS OF INJURY: DATE OF INJURY: MM DD YYYY

JOINT INVOLVED:

DATE EXPECTED TO FULL FITNESS: MM DD YYYY

SURGERY REQUIRED? ☐ YES ☐ NO

SIDE OF INJURY: ☐ RIGHT ☐ LEFT

IF SURGERY REQUIRED, PLEASE PROVIDE FULL DETAILS:

3. Have you missed more than 14 consecutive days from his sport due to injury, sickness, disease or discomfort during the last five years? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

4. Have you taken any prescribed medicine, including courses of cortisone, pain reducing or anti-inflammatory medication for a period in excess of 7 days during the last two years? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

5. Have you had any X Rays, CAT scans, M.R.I. Scans or any other radiological investigations within the last two years? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

6. Have you suffered concussion or unconsciousness within the last 5 years? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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7. Do you have any reason to believe that you may need any medical treatment or undergo surgery in the future? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

8. Are you allergic to, or have you ever had any adverse reaction to any medicine(s) or other substance(s)? ☐ YES ☐ NO

IF YES, PLEASE ADVISE WHEN WAS THE LAST EXAM:

9. Have you ever suffered injury or had any treatment, or have any abnormality to the following body parts or conditions?

A. Head	☐ YES ☐ NO	L. Hamstring (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
B. Neck	☐ YES ☐ NO	M. Knee (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
C. Shoulder (IF YES, SPECIFY SIDE)	☐ YES ☐ NO	N. Patellar Tendonopathy (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
D. Back (INCLUDING SPINAL COLUMN)	☐ YES ☐ NO	O. Shin (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
E. Arm (IF YES, SPECIFY SIDE)	☐ YES ☐ NO	P. Calf (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
F. Elbow (SPECIFY SIDE)	☐ YES ☐ NO	Q. Ankle (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
G. Hands (INCLUDING WRISTS - SPECIFY SIDE)	☐ YES ☐ NO	R. Achilles Tendonopathy (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
H. Fingers	☐ YES ☐ NO	S. Foot (IF YES, SPECIFY SIDE)	☐ YES ☐ NO
I. Hips	☐ YES ☐ NO	T. Toes	☐ YES ☐ NO
J. Groin	☐ YES ☐ NO	U. Arthritis/Osteoarthritis	☐ YES ☐ NO
K. Thigh (IF YES, SPECIFY SIDE)	☐ YES ☐ NO	V. Any other degenerative condition	☐ YES ☐ NO

PLEASE PROVIDE DETAILS INCLUDING BODY PART / CONDITION, DIAGNOSIS INCLUDING GRADE, DATE OF INJURY/DIAGNOSIS, DATE OF RECOVERY, DETAILS OF ANY SURGERY, DETAILS OF ANY RADIOLOGICAL INVESTIGATIONS, AND CURRENT CONDITION, TO ANY QUESTIONS ABOVE ANSWERED "YES".

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10. Have you ever shown indications of, suffered from, been treated for, have any enlargement or abnormality of, or been prescribed medication for, any of the following?

A. Heart (INCLUDING CHEST & CIRCULATORY SYSTEM)	☐ YES ☐ NO	**F.** Skin	☐ YES ☐ NO
B. Blood Pressure or Diabetes	☐ YES ☐ NO	**G.** Respiratory System	☐ YES ☐ NO
C. Nervous System or Fits	☐ YES ☐ NO	**H.** EKG	☐ YES ☐ NO
D. Dizziness or Fainting	☐ YES ☐ NO	**I.** Abdomen	☐ YES ☐ NO
E. Head (INCLUDING EYES, EARS, NOSE, THROAT, & MOUTH)	☐ YES ☐ NO	**J.** Genitalia	☐ YES ☐ NO

PLEASE PROVIDE DETAILS INCLUDING BODY PART / CONDITION, DIAGNOSIS INCLUDING GRADE, DATE OF INJURY/DIAGNOSIS, DATE OF RECOVERY, DETAILS OF ANY SURGERY, DETAILS OF ANY RADIOLOGICAL INVESTIGATIONS, AND CURRENT CONDITION, TO ANY QUESTIONS ABOVE ANSWERED "YES".

11. Have you had any other operations or invasive medical treatment (i.e. injections) or suffered any other accident or sickness not already mentioned on this proposal form? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

12. Have you suffered from any other medical condition not mentioned in this proposal form? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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DETAILS REPORT FORM

Please provide full details including:

- Body part / condition
- Date of injury/diagnosis, date of recovery
- Diagnosis including grade
- Details of any surgery
- Details of any radiological investigations
- Current condition

PLEASE INCLUDE QUESTION NUMBER

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DECLARATION

a) I / We warrant that this proposal and questionnaire has been completed to the best of my / our knowledge and belief and that all statements and particulars provided by me / us are true and complete

b) I / We have NOT misstated, omitted, or suppressed any material fact or information (a material fact is one which is likely to influence an Insurer's assessment and acceptance of a proposal. If you are in any doubt as to whether a fact is material or not you are advised that it is in your own interest to disclose all facts). I/We understand that non-disclosure or misrepresentation of a material fact may entitle the Insurer to void the insurance.

c) I / We agree that this proposal and questionnaire and any information provided in connection with it shall form the basis of the contract between me / us and the Insurer, and to be bound by the terms and conditions of the policy. I / We understand the Insurer will determine their terms and conditions upon this information.

d) If there is any material alteration to the facts or information which I / we have provided or any new material matter arises before completion of the contract of Insurance, I / we undertake to inform Insurers.

e) I / We agree that if any answers have been written by another person then for that purpose such person will be regarded as my / our agent and not the agent of the Insurer.

f) I / We are authorised to sign on behalf of all proposers.

g) I / We understand that
   i) The liability of the Insurer does not commence until this proposal has been accepted by them
   ii) The Insurers reserve the right to decline any proposal

h) I / We agree to the seeking of information from credit and other agencies in connection with this proposal.

i) I / We understand that the existence of any procedures for dealing with complaints do not prejudice my / our right to take legal action against Insurers.

You have the right to access (subject to limited exceptions) or to amend the information we hold about you. If you would like to exercise either or these rights please contact the Insurers When our clients supply us with information containing personal data (names, addresses, or other information relating to living individuals), we hold and use that data to perform general and other services for those clients on the understanding that the individuals to whom the data relates have been informed of the reason(s) for obtaining data and the fact that it may be disclosed to third parties such as the Insurers.

Insurers may pass information to crime prevention and anti-fraud registers and databases. These may also be searched when dealing with your request for insurance. Under the conditions of your policy, you must declare all incidents whether or not they have resulted in a claim.

Signature of Proposer | **Date (MONTH/DAY/YEAR)** | **Full Name of Proposer**

Signature of Proposed Insured Person | **Date (MONTH/DAY/YEAR)** | **Full Name of Proposed Insured Person**

AGENT STATEMENT

I certify that I have truly and accurately recorded all the information given to me by the applicant, and I certify that I know of no other medical information about the person applying for coverage other than that contained on this application. I certify that the applicant has either filled out the application or has personally reviewed the completed application. I have explained all policy benefits, exclusions and limitations.

Producing Agent's Signature | **Producing Agent's Name (please print)**

Date | **Agency Name**

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HIPAA Compliant Authorization for Release of Health Related Information

Name of Proposed Insured:

FIRST NAME | M.I. | LAST NAME

Date of Birth:

MM | DD | YYYY

I authorize any health plan, physician, health care professional, Hospital, Clinic, Laboratory, pharmacy or pharmacy benefit manager, or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau or any other organization, institution or person that has any records or knowledge of me or my health, to give to International Specialty Insurance, any such information, to the extent permitted by law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or team trainer to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that International Specialty Insurance may: 1) work with underwriters to have the exclusions (if any) removed from my insurance policy; 2) conduct other legally permissible activities that relate to any coverage I have or have applied for with International Specialty Insurance.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand I have the right to revoke this authorization in writing, at any time, by providing written notification to International Specialty Insurance at 110 Oakwood Drive, Suite 420, WinstonSalem, NC 27103. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me.

I understand that any information that is disclosed is in pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by International Specialty Insurance except as authorized by me or as required by law. I understand that International Specialty Insurance may not be able to process my application if I refuse to sign this Authorization. I further understand that if coverage has been issued, International Specialty Insurance may not be able to assist in removing medical exclusions placed on my insurance policy by underwriters or make any benefit payments. I understand that I or any authorized representative may receive a copy of this Authorization upon request.

Signature of Proposed Insured/Patient or Date Personal Representative

Date (MONTH/DAY/YEAR)

Signature of Witness

Date (MONTH/DAY/YEAR)