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.

Athletes Disability Insurance Application

1. Proposed Insured:

FIRST NAME | M.I. | LAST NAME

ADDRESS

CITY | STATE | ZIP CODE

SOCIAL SECURITY NO.

GENDER: ☐ MALE ☐ FEMALE

WEIGHT: HEIGHT:

Date of Birth:

MM | DD | YYYY

Place of Birth:

2. Policyholder/Assured: (IF OTHER THAN PROPOSED INSURED)

FIRST NAME | M.I. | LAST NAME

ADDRESS

CITY | STATE | ZIP CODE

3. Occupation:

4. Do you have any other full time or part time employment? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

5. Have you had your Driver's License revoked, suspended or restricted? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

6. Are you presently applying, have in force, or applying to reinstate any disability insurance? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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7. Have you ever had any Life, Health or Accident insurance ever canceled or declined? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE REASON(S) FOR DECLINATION, SPECIAL TERMS AND/OR CONDITIONS:

8. Have you and/or Policyholder/Assured ever made any claim(s) against an insurer or any self-insured plan for disability resulting from injury or sickness? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

9. Are you currently free of injury, illness or discomfort? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

10. Are you currently physically able to perform all of the duties required in your sport/occupation? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

12. Have you missed any playing time during the last 24 months as a result of injury, illness, discomfort or for any other reason? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE FULL REASON(S) AND DATE(S) FOR EACH SUCH OCCURRENCE:

13. Do you require any type of knee brace while playing or practicing? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

14. Name and address of Personal Physician.

15. If you have consulted your Personal Physician in the last 24 months, please give date and reason for consultation.

16. Does the Physician named in the question above also act as the physician for the team for which you play? ☐ YES ☐ NO

17. Have you consulted your team physician or any other physician in the last 24 months other than for routine examination or team physical? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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18. Have you in the last 24 months taken any pain reducing or anti-inflammatory medication? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

19. Have you been advised or have any reason to believe that you may need medical treatment in the future? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

20. Do you engage in any of the following activities, or any other similar activities which may be considered hazardous; Piloting an aircraft, skydiving or hang-gliding, water or underwater sports, winter sports (other than skating or curling), motor sports or motorcycling, rock climbing or mountaineering, any other activities excluded by your club contract? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

21. Are you now or have you ever been treated for substance abuse or alcohol abuse? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

22. Have you ever used marijuana, mood-altering drugs, narcotics, cocaine, heroin, barbiturates, LSD or amphetamines? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

23. Have you ever been diagnosed or received treatment by a member of the medical profession for AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME) OR ARC (AIDS RELATED COMPLEX)? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

24. Have you ever been advised to have treatment to have treatment which has not been undertaken? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

25. Have you been advised to take medication which you have not undertaken? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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Athletes Disability Insurance Application

26. Have you ever undergone hospitalization or treatment exceeding 14 days as a result of sickness or disease or a non-injury condition? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

27. Have you ever injured or suffered pain or discomfort or had surgery to any of the following:

A. Head? (INCLUDING CONCUSSION)?	☐ YES ☐ NO	M. Left Hand (INCLUDING WRIST & DIGITS)?	☐ YES ☐ NO
B. Neck (NECK OR CERVICAL SPINE)?	☐ YES ☐ NO	N. Right Thigh (INCLUDING HAMSTRING)?	☐ YES ☐ NO
C. Right Shoulder (INCLUDING CLAVICLE & SHOULDER BLADE)?	☐ YES ☐ NO	O. Left Thigh (INCLUDING HAMSTRING)?	☐ YES ☐ NO
D. Left Shoulder (INCLUDING CLAVICLE & SHOULDER BLADE)?	☐ YES ☐ NO	P. Right Knee?	☐ YES ☐ NO
E. Chest (INCLUDING RIBS, STERNUM & DIAPHRAGM)?	☐ YES ☐ NO	Q. Left Knee?	☐ YES ☐ NO
F. Upper Back? (THORACIC SPINE)?	☐ YES ☐ NO	R. Right Lower Leg?	☐ YES ☐ NO
G. Lower Back (LUMBAR SPINE INCLUDING COCCYX AND TAIL BONE)?	☐ YES ☐ NO	S. Left Lower Leg?	☐ YES ☐ NO
H. Pelvis/Hips (INCLUDING GROIN – SPECIFY SIDE)?	☐ YES ☐ NO	T. Right Ankle (INCLUDING ACHILLES TENDON)?	☐ YES ☐ NO
I. Abdomen (INCLUDING STOMACH)?	☐ YES ☐ NO	U. Left Ankle (INCLUDING ACHILLES TENDON)?	☐ YES ☐ NO
J. Right Arm (INCLUDING ELBOW)?	☐ YES ☐ NO	V. Right Foot?	☐ YES ☐ NO
K. Left Arm (INCLUDING ELBOW)?	☐ YES ☐ NO	W. Left Foot?	☐ YES ☐ NO
L. Right Hand (INCLUDING WRIST & DIGITS)?	☐ YES ☐ NO		

PLEASE PROVIDE DETAILS INCLUDING DATES (DAY/MONTH/YEAR) TO ANY QUESTIONS ABOVE ANSWERED "YES".

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

A. Cardiac such as heart murmur, heart attack, angina, blood pressure, or any other disease of the heart or blood vessels?	☐ YES	☐ NO
B. Respiratory system such as asthma, chronic bronchitis or emphysema, shortness of breath, pneumonia or any other respiratory disease?	☐ YES	☐ NO
C. Digestive such as ulcer, colitis, bleeding, gallbladder or liver disease or any other disorder of the stomach, intestines or rectum?	☐ YES	☐ NO
D. Nervous system such as paralysis, anxiety, seizures, depression or any other mental disease?	☐ YES	☐ NO
E. Endocrine such as diabetes, thyroid, or any other glandular disease?	☐ YES	☐ NO
F. Any disease of the blood?	☐ YES	☐ NO
G. Skin disease, cancer, cyst or tumor?	☐ YES	☐ NO
H. Rheumatism, arthritis, ruptured disc, or any disease, injury or deformity of the spine, joints, bones or muscles?	☐ YES	☐ NO
I. Any disease of the kidneys, bladder, prostate or reproductive organs?	☐ YES	☐ NO
J. Pelvis/Hips (including groin – specify side)?	☐ YES	☐ NO
K. Any disease of the eyes, ears, nose or throat?	☐ YES	☐ NO
L. Concussions, loss of consciousness, or seizures?	☐ YES	☐ NO
M. Paralysis whether complete or partial, regardless of length of time or duration?	☐ YES	☐ NO

PLEASE PROVIDE DETAILS INCLUDING DATES (DAY/MONTH/YEAR) TO ANY QUESTIONS ABOVE ANSWERED "YES".

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29. Have you suffered any other injuries, discomfort or conditions to:

Bones	☐ YES ☐ NO	Muscles	☐ YES ☐ NO
Joints	☐ YES ☐ NO	Nerves	☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

30. Have you ever undergone surgery as a result of sickness or disease or a non – injury condition? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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 the 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.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I, the Proposed Insured, declare that all responses made to each and every question in the Application are truce and complete. I understand that:

A. Any false statements or material misrepresentations shall result in the loss of coverage under any policy and/or certificate which may be in force and/or any coverage which are being offered; and

B. No representation made to or information possessed by any agent shall be binding on the Underwriters and/or the Insurer, unless disclosed in the Application.

Signature of Proposed Insured

Printed Name

Date

Signed at (City, State)

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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

THE FOLLOWING DECLARATION IS ONLY TO BE COMPLETED WHERE A TEAM IS EFFECTING THIS INSURANCE ON BEHALF OF THE 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 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.

Date (MONTH/DAY/YEAR)

Signature of Team Official

Title

PLEASE RETURN COMPLETED FORMS TO:

INTERNATIONAL SPECIALTY INSURANCE
110 Oakwood Dr : Ste. 420
Winston-Salem, NC 27103

PHONE: 336.835.2230 : FAX: 336.835.1729
www.isinsurance.com

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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)