

PROFINANCIALSERVICES

High Limit Disability Insurance

Administrative Offices

PRO FINANCIAL SERVICES, INC.

1450 E. American Lane,
Suite 1650
Schaumburg,
Illinois 60173-6086



(847) 619-6699
Fax: (847) 619-5533
1(800) 832-8000

MEDICAL EXAMINER'S REPORT

***For Athlete's
Disability Income
Protection***

Part II of II



*Underwritten by
ACE American Insurance Company*

PROPOSED INSURED'S NAME:

ATHLETE'S DISABILITY INCOME PROTECTION

(All questions must be answered in ink. Please print clearly.)

Failure to answer all questions completely with full details will result in a delay in underwriting.

Wherever 'Yes' or 'No' answers require full details, these should be given in the space provided.

If there is not sufficient space, use space provided on back page or attach your answers on a separate sheet.

ALL of the following sections must be completed by the Medical Examiner upon examination of the Proposed Insured.

SECTION 1 GENERAL INFORMATION

1. Name of Proposed Insured:

_____ First _____ Middle _____ Last

2. Date of Birth: _____

3. Name of Team: _____

Professional
 Collegiate
 Other (please state) _____

4. Position: _____

5. Have you examined and/or treated the Proposed Insured in the past ten (10) years? YES for _____ (number of) years
 NO

SECTION 2 MEDICAL HISTORY

Proposed Insured's:

1. Height _____ 2. Weight _____

3. Blood Pressure _____ 4. Pulse _____

5. Please check the appropriate box: *If any of the items are deemed abnormal please provide clinical definition of abnormality as well as details and results of any diagnostic tests performed.*

	Normal	Abnormal	Details
Head, Eyes, Ears, Nose or Throat:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones, Glands or Skin:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs or other Respiratory Organs:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart, and the cardiovascular system including blood vessels:	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or other Abdominal Organs:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genito-Urinary Organs (including prostate or hernias):	<input type="checkbox"/>	<input type="checkbox"/>	_____

For administrative purposes, make sure Proposed Insured's name and date of birth are filled in at the bottom of **each** of the following pages.

PROPOSED INSURED: _____ Date of Birth: ____/____/____

SECTION 3 MEDICAL HISTORY (continued)

*For Section 3,
Questions 6 through 10 :*

*Please answer YES or NO
as to whether or not the
Proposed Insured within
the past ten (10) years has
suffered any discomfort or
injury or required treatment
with respect to each body
part.*

Please give full details.

6. UPPER BACK (thoracic spine) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
7. LOWER BACK (lumbar spine including coccyx & tail bone) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
8. PELVIS/HIPS (including groin - specify side) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
9. ABDOMEN (including stomach) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
10. RIGHT ARM (including elbow) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

PROPOSED INSURED: _____ Date of Birth: ____/____/____

SECTION 3 MEDICAL HISTORY (continued)

**For Section 3,
Questions 11 through 15 :**

*Please answer YES or NO
as to whether or not the
Proposed Insured within
the past ten (10) years has
suffered any discomfort or
injury or required treatment
with respect to each body
part.*

Please give full details.

11. LEFT ARM (including elbow) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
12. RIGHT HAND (including wrist, fingers and thumb) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
13. LEFT HAND (including wrist, fingers and thumb) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
14. RIGHT THIGH (including hamstring) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:
15. LEFT THIGH (including hamstring) <input type="checkbox"/> YES <input type="checkbox"/> NO Normal Exam Result? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Date(s):	Details (discomfort, injury or treatment):	Details of any Surgery:	Current Prognosis:

PROPOSED INSURED: _____ Date of Birth: ____/____/____

