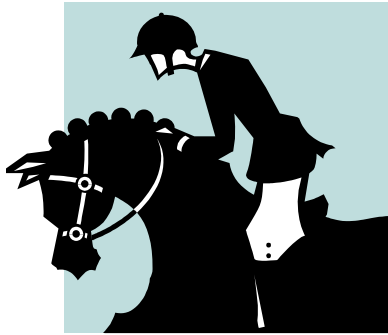


HIGH LIMIT PROFESSIONAL ATHLETE INSURANCE



Loss of Future Earnings, Contract Completion, Loss of Endorsements, Cost of Agents/Managers, College Draft Protection, High Limit Death & Dismemberment Benefits

**Cossio Insurance Agency
107 Old Laurens Rd
Simpsonville, SC 29681
(864) 688-0121
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www.cossioinsurance.com**

“The Nation’s Leader In Sports Insurance”

Section 1

Name of Proposed Insured _____

Address of Proposed Insured _____

Date of Birth _____

Sex: Male Female

Height _____

Weight _____

Proposed Insureds Occupation _____

Name of Team _____

Position _____

Do you have any other full or part-time employment? Yes No

If Yes, describe _____

Employer _____

Employer Address _____

Nature of Business _____

Date of Current Contact Expiration _____

Are you actively working in this occupation? Yes No

If No, describe _____

How long have you been working as a professional in this occupation? _____

Other Past Employment: _____

Next Contact/Year Estimated Salary \$ _____

Last Contact/Year Salary Amount \$ _____

Section 2

Policy Owner: Insured Other

If Other, Name _____

Address _____

Description of Relationship to Insured Person _____

Section 3

Do you currently have or do you anticipate purchasing any other disability insurance? Yes No

If Yes, describe _____

Have you during the last five years been insured for disability whether purchased by yourself or any other person on your behalf? Yes No

If Yes, describe _____

Have you ever had a proposal for disability insurance declined or accepted with special conditions or exclusions imposed? Yes No

If Yes, describe _____

Do you participate in winter sports other than skating or curling? Yes No

If Yes, describe _____

Do you participate in water or underwater sports? Yes No

If Yes, describe _____

Do you participate in rock climbing or mountaineering? Yes No

If Yes, describe _____

Do you participate in motor sports or motorcycling? Yes No

If Yes, describe _____

Do you participate in any activities that are excluded under your organization contract? Yes No

If Yes, describe _____

Section 4

Are you at present free of injury, illness or discomfort? Yes No

If No, describe _____

Are you currently physically able to perform all of the duties required in your sport? Yes No
If No, describe

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, describe

If you have visited your personal physician in the last 24 months, please provide dates and reasons for consultations.

Name of Personal Physician:

Address of Personal Physician:

Does your personal physician also act as the team or organization physician? Yes No

Have you consulted your team or organization physician in the last 24 months other than for routine examinations? Yes No

If Yes, describe

Have you within the last 24 months taken any pain reducing medication or anti-inflammatory medication? Yes No

If Yes, describe

Have you within the last 12 months suffered any injury, illness or discomfort for which you have not sought treatment for? Yes No

If Yes, describe

Have you been advised or do you have reason to believe that you will need to seek medical treatment in the future? Yes No

If Yes, describe

Have you been advised to have surgery which has not yet been undertaken? Yes No

Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? If Yes, please provide written details and use additional paper if necessary.

A. Head? Yes No

- B. Neck (Cervical Spine)? Yes No
- C. Right Shoulder? Yes No
- D. Left Shoulder? Yes No
- E. Chest (Including Ribs)? Yes No
- F. Upper Back (Thoracic Spine)? Yes No
- G. Lower Back (Lumbar Spine)? Yes No
- H. Pelvis or Hips (Including Groin)? Yes No
- I. Abdomen (Including Stomach)? Yes No
- J. Right Arm (Including Elbow)? Yes No
- K. Left Arm (Including Elbow)? Yes No
- L. Right Hand (Including Wrist and Fingers)? Yes No
- M. Left Hand (Including Wrist and Finders)? Yes No
- N. Right Thigh (Including Hamstring)? Yes No
- O. Left Thigh (Including Hamstring)? Yes No
- P. Right Knee? Yes No
- Q. Left Knee? Yes No
- R. Right Lower Leg (Including Ankle)? Yes No
- S. Left Lower Led (Including Ankle)? Yes No
- T. Right Foot? Yes No
- U. Left Foot? Yes No

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

- A. Bones? Yes No
- B. Joints? Yes No
- C. Muscles / Nerves? Yes No

Have you ever undergone surgery as the result of sickness, disease or a non-injury condition?

Yes No

If Yes, describe

Have you ever undergone hospitalization or treatment exceeding fourteen days as the result of sickness, disease, or a non-injury? Yes No
If Yes, describe _____

Have you ever been advised that such surgery may be required in the future? Yes No
If Yes, describe _____

Have you ever been prescribed any of the following which have not been undertaken?

Medication? Yes No
If Yes, describe _____

Diagnostic Tests? Yes No
If Yes, describe _____

Surgery? Yes No
If Yes, describe _____

Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any conditions of the following? If Yes, please describe.

Ears, Nose or Throat? Yes No
Respiratory? Yes No
Stomach? Yes No
Gout? Yes No
Cancer or Related Diseases? Yes No
Liver or Kidneys? Yes No
Seizures? Yes No
Concussions? Yes No
Thyroid Problem? Yes No

Heart or Chest? Yes No
Blood Pressure? Yes No
Bladder? Yes No
Hernia? Yes No
Arthritis? Yes No
Epilepsy? Yes No
Mental Disorders? Yes No
Paralysis? Yes No
Partial Paralysis? Yes No

Have you ever suffered sickness not associated with any of the above, for which resulted in confinement of greater than seven days? Yes No
If Yes, describe _____

Please give details of any family history of any of the conditions mentioned under the above previous two questions (ie Mother, Father, Brothers, Sisters).

Section 5

Coverage Requested:

- Loss of Future Earnings
- Loss of Endorsements
- College Draft Protection

- Contract Completion
- Cost of Agents/Managers
- High Limit Death & Dismemberment Benefits

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. No agent, broker or medical examiner has the authority to waive the answers to any question, to determine insurability, to waive any of the Underwriters rights or requirements, or to make or alter any contract or policy.
3. The Underwriter 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 OBTAIN INFORMATION

To all physician's, medical professionals, hospitals, clinics, other health care providers, insurers, employers, Medical Information Bureau (MIB), consumer reporting agencies, other insurance support organizations, and other person who have information about the proposed insured:

I authorize you to give Lloyds of London, 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 an 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.

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.

DATE

SIGNATURE OF THE PROPOSED INSURED

The following declaration is ONLY to be completed where a team or organization 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 contract of insurance.

DATE

SIGNATURE OF TEAM / ORGANIZATION OFFICIAL

TITLE

