ProSight® Specialty Insurance

CAST STATEMENT OF HEALTH

Name of Artist

Date of Birth Age

Sex Height

Weight

Artist's Role ☐ Actor ☐ Director ☐ Other (describe)

Name of Production

Production Company

How long will you be working on this production? (start date/end date)

Artist's Statement of Health

(Must be completed by artist shown above)

1. Name, address and telephone number of General Practitioner (if none, so state)
2. When were you last examined? Why?

   Results

3. To the best of your knowledge are you in good health and free from physical impairment or disease? Yes ☐ No ☐
4. Have you, to the best of your knowledge and belief, ever had or been informed you have /had, been treated for, or consulted a doctor regarding any of the following?

   (Please tick the appropriate boxes and give full details in the space provided on next page)

   If any of the following are answered "Yes" please explain in the space provided on the "Comments" section overleaf

(a)	Allergies, anaemia or disorder of the blood?	Yes ☐	No ☐
(b)	Any disease, disorder or injury of the bones, joints, muscles, back, spine, or neck?	Yes ☐	No ☐
(c)	Any disorder of the skin, lymph glands, immune system, cyst, tumor or cancer?	Yes ☐	No ☐
(d)	Any infections or diseases of eyes, ears, nose or throat in the past 5 years?	Yes ☐	No ☐
(e)	Cold sores on lips or face in the past 5 years?	Yes ☐	No ☐
(f)	Convulsions, paralysis or stroke, fainting attack, severe headaches or disease of the brain or nervous system?	Yes ☐	No ☐
(g)	Diabetes, gout or any disease or abnormality of the thyroid or other glands?	Yes ☐	No ☐
(h)	Duodenal or gastric ulcer, colitis, or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder or hernia?	Yes ☐	No ☐
(i)	High blood pressure, heart attack, pain in chest, or any other disorder of the heart or blood vessels?	Yes ☐	No ☐
(j)	Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder of the bladder, kidney or genito-urinary system?	Yes ☐	No ☐

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(k) Tuberculosis, asthma, emphysema, persistent cough or any disease or abnormality of the lungs or respiratory system? Yes ☐ No ☐

(l) In the last year, have you had any significant change (i.e. more than 20 pounds or 10%) of body weight (other than pregnancy)? Yes ☐ No ☐

(m) Excessive use of alcohol or drugs, use of tobacco in any form? Yes ☐ No ☐

(n) Used LSD, Heroin, Cocaine or any other narcotic, depressant, stimulant or psychedelic whether or not prescribed by a physician in the last 3 years? Yes ☐ No ☐

(o) Been exposed to any infectious or contagious disease in the last 21 days? Yes ☐ No ☐

(p) At any time within the past five years have you consulted a doctor, been under a doctor's care, had surgical advice or treatment or been confined to a hospital? Yes ☐ No ☐

(q) Suffer from any phobias or are you aware of any mental health problems that may prevent you from carrying out our scheduled production activities? Yes ☐ No ☐

(r) Now taking or in the past 30 days taken any medicine or health treatments? Yes ☐ No ☐

Comments

For any "yes" answers, please provide details including diagnosis, treatment, results, dates of disability, degree of recovery and name and address of attending doctor.

5. To be completed if the artist is a female

(a) Have you had any disorder of menstruation, pregnancy or the female organs or breasts? Yes ☐ No ☐

(b) To the best of your knowledge are you now pregnant? Yes ☐ No ☐
If "yes", how many months? ______ months

6. If, under age 9 years, please advise what childhood diseases you have had, and attach a copy of your immunization record

7. Are there any other conditions (medical or otherwise) that might affect your ability to perform your duties on this production? Yes ☐ No ☐
If "yes", please explain

8. During the past three years, have you missed any work time as a result of illness or injury while in any film or stage production? Yes ☐ No ☐
If "yes", please give details (production title, days missed, cause of absence)

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9. Are you now or will you be at any time during the period of production involved in any stunt work or employed on or performing in any other film, stage or other professional engagement? Yes ☐ No ☐
If "yes", state full particulars and dates

10. Are you now or will you at any time during the period of production be involved in any potentially hazardous physical activities? Yes ☐ No ☐
If "yes", please provide further details

11. Has any insurance company declined to insure you or imposed any special terms in regard to your acceptance for any Cast Insurance, Non-Appearance Insurance or Accident, Health or Life Insurance? Yes ☐ No ☐
If "yes", please provide further details

12. Will you participate in any of the following physical activities or sports whilst you are contracted to this production? Yes ☐ No ☐

Auto Racing	☐	Ballooning	☐	Gliding/Flying	☐
Motorcycle Racing	☐	Equestrian Activities	☐	Marathons/Triathlons	☐
Skiing	☐	Sky Diving	☐	Scuba Diving	☐
Mountain Climbing	☐	Others *please specify*			

13. Do you have any contractual provisions stating the maximum number of hours per week, per day or days per week to work? Yes ☐ No ☐

If "yes", please indicate hours per day days per week

By signing this Statement of Health Form you consent to ProSight using the information we hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

I DECLARE that I am the person named above; that the statements made by me are true and correct; that I have withheld no information known to me which might alter or otherwise conflict with the statements made by me. I understand that an insurance policy may be issued based on these statements made by me. If a policy is issued and a claim is paid I understand that the insurer may seek recoupment from me if it is determined that the statements I have made are not true and correct, or that I have withheld information known to me which might alter or otherwise conflict with these statements I have made. I also agree to be examined by the insurer's doctors in the event a claim is made.

I AUTHORISE ProSight to have access to my medical records for underwriting and claims purposes. I acknowledge that I may request a copy of this authorisation. I agree that this authorisation shall be valid for a period of six months, or until any claim is resolved in which I am involved.

Signature of Declared Artist/Guardian

Date

PLEASE PRINT NAME IN CAPITALS