XL Insurance

Media and Entertainment

Cast Insurance Medical Certificate

Production Company:	
Production Title:	
Name of Artist:	
Artist's Role:	

Artist's First Day of Principal Photography:		Estimated period of working on Production:					
Birth Date:		Age:		Height		Weight:	

Artist's Statement of Health (must be completed by artist shown above)

(1) If you have ever had, been advised you had, been treated for, or consulted a doctor regarding any of the following medical conditions, please circle the letter relevant to the appropriate item and provide full details in the space below.

A. Convulsions, paralysis or stroke, fainting attacks; severe headaches, disease of the brain or nervous system

B. High blood pressure, heart attack, pain in chest or any other disorder of the heart or blood vessels

C. Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs of respiratory system

D. Duodenal or gastric ulcer, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder, or hernia

E. Sugar, albumin, blood or pus in urine, kidney stones or any other disorder to the bladder, kidney or genito-urinary system

F. Diabetes, gout or any disease or abnormality of the thyroid or other glands

G. Any disease, disorder or injury of the bones, joints, muscles, back, spine or neck

H. Disorder of the skin, lymph glands, cyst, tumour or cancer

I. Disorder of eyes, ears, nose or throat

J. Cold sores on lips or face in past five years

K. Allergies, anaemia or other disorder of the blood

L. Any eating disorder

M. Significant (more than ten pounds) change of weight in the past year (other than pregnancy) or participated in any diet programs

N. Excessive use of alcohol or drugs, use of tobacco in any form

O. Used LSD, heroin, cocaine or any other narcotic, depressant, stimulant or psychedelic whether or not prescribed by a physician in the last three years

P. Been exposed to any infection or contagious disease in the last 21 days

Q. Under a doctor's care for any physical or mental condition during the past five years

R. Had surgical advice or treatment or been confined to a hospital during the past five years

S. Suffer from any phobias or are you aware of any mental health problems that have in the past caused you to be disabled or may in the future prevent you from carrying out your scheduled production activities

T. Now taking or in the past 30 days taken any medicine or health treatments

For all circled items please provide diagnosis, treatment, results, dates of disability, degree of recovery, name and address of attending physician:

Item:	Details:

(2)

To the best of your knowledge are you now pregnant? **Yes** ☐ **No** ☐

If 'Yes', how many months?

How many pregnancies have you had?

Any complications?

(3) If you have missed any time on any production or tour in the last 3 years, please give details:

Production Tour/Title:	Days Missed:	Cause of Absence:

(4) To the best of your knowledge, 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 or Health or Life Insurance?

If **Yes**, please provide full explanation: Yes ☐ No ☐

(5) Name, address and telephone number of your personal physician?

(6) When was your last examination? Why?

(7) How often do you have a full physical exam?

(8) To the best of your knowledge and belief, are you in good health and free from physical impairment or disease?

If 'No', please give full details: **Yes** ☐ **No** ☐

(9) Are you now or will you at any time during the period of production be in any other film, stage or other professional engagement?

If **Yes**, please give full details and dates: **Yes** ☐ **No** ☐

(10) If under 9 years of age, please advise what childhood diseases you have had and attach a copy of your immunisation record:

(11) Do you participate in any of the following physical activities or sports during your personal time?

☐ Auto Racing ☐ Ballooning ☐ Gliding/Flying ☐ Motorcycle Riding/Racing
☐ Equestrian Activities ☐ Marathons/Triathlons ☐ Skiing ☐ Sky Diving
☐ Scuba Diving ☐ Mountain Climbing ☐ Other _____

For activities confirmed, please give details:

(12) Please indicate all roles or responsibilities that you will have on this production:

☐ Leading Actor ☐ Supporting Actor ☐ Cameo ☐ Director ☐ Director of Photography
☐ Exec. Producer ☐ Co-Producer ☐ Producer ☐ Writer
☐ Other: _____

(13) Will you be performing any special physical activities that require practice or training?

If **Yes**, please give full details: **Yes** ☐ **No** ☐

(14) Do you have any contractual provisions stating the maximum number of hours per week, per day or days per week to work?

If **Yes**, please indicate hours per day/week / days per week: **Yes** ☐ **No** ☐

Do you have a stop date in your contract? If **Yes**, please indicate below. **Yes** ☐ **No** ☐

(15) Do you or any member of your household have a job with increased exposure to Covid-19 infection?

If **Yes**, please give full details: Yes ☐ No ☐

I declare and affirm that I am the person named on this form; that the statements made hereon by me are true, correct and complete; that I have withheld no information known to me which might alter or conflict with the statements made by me. I understand that a Contract of Insurance may be issued and claim settlements made based upon the representations and facts stated by me as true. In the event a Contract of Insurance is issued and a claim is paid, I understand that the Insurers will hold me fully and personably liable and will seek recoupment from me if it is determined that the facts stated herein are not true, correct or complete or that I withheld information which conflicts with the statements I made. I also agree to be re-examined by the Insurers' doctor in the event a claim is made.

I authorise any physician, practitioner, hospital, clinic, laboratory, other medical facility or health care provider, insurance company, reinsurance company or production company having information regarding diagnosis, treatment a nd prognosis of any medical or mental condition to permit Insurers or their duly authorised representatives to review an d copy all medical reports, X-rays, charts, records and other data which may pertain in any manner to my medical history, physical or mental condition, care and/or treatment. I understand that the medical information obtained will be used by Insurers for underwriting and claim settlement purposes. I agree that this authorisation for release of medical information shall be valid until a Cast claim relating to the examinee has been settled and closed with the Insur ed Producer. A copy of this form shall be considered as valid as the original and I understand that I may obtain a copy of this authorisation if I so request it.

I also understand that you, and persons acting for you, may disclose this information to your agents, brokers, and other authorized representatives, who may collect and use this information only as reasonably necessary to enable you to carry out the purposes described above.

I declare and affirm that during the period of time for which I am participating in the above production, I will continue to take any medications or follow any course of treatment currently or prospectively prescribed to me by my doctors.

Signature of Applicant:		Dated:	
Signature of Guardian:		Dated:	

Physical Examination

(to be completed by the examining Doctor)

Date of Examination:	
Location of Examination:	
Examining Doctor:	
Doctor's address and telephone number:	

General Appearance:		Height:		Weight:	
Temperature:		Blood Pressure:		Pulse:	
EENT:		Heart:		Lungs:	
Abdomen:		Back:		Face:	

Doctor's Comments

Complete any further examination you deem necessary as a result of your findings or Examinee's history. Please comment on any special feature revealed by examinee in their replies in the first part of this form with notes on examination and any abnormal findings and recommendations:

I have today examined the above named artist/performer and in my opinion | **he** | **she** | | **is** | **is not** | (cross/delete as applicable) in sound health and free from disease and is in a fit condition, subject to any qualifications mentioned above, to fulfil his/her production / performance / engagement.

A Supplemental Medical Report was performed and is attached hereto _____.

I | **have** | **have not** | (circle as applicable) performed a Cast Medical Exam on this applicant prior to today.

Signature of Doctor: _____ Dated: _____

DD / MM / YYYY

Once complete, please send this form to castexam@axaxl.com.

A Copy of this Form Shall be Considered as Valid as The Original

Fair Processing Notice

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The information provided to the Insurer, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, analytics relevant to insurance, rehabilitation and customer concerns handling) and fraud prevention and detection. We may be required by law to collect certain personal information about you, or as a consequence of any contractual relationship we have with you. Failure to provide this information may prevent or delay the fulfilment of these obligations.

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