CHUBB

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Cast Insurance Medical Certificate

Production Company: _____ Date/Time of Exam: _____

Production Title: _____ Location: _____

Name of Applicant: _____ Physician: _____

Applicant's First Day of Principal Photography: _____ Address: _____

Estimated # of Weeks Working on Production: _____ Telephone No: _____

Fax No: _____

Part 1 – Medical Information

1. Birth Date (MM/DD/YYYY): _____ Age: _____ Sex: _____

2. Have you ever had, been advised you had, been treated for, or consulted a doctor regarding any of the following? If YES, please give full details in the space provided below.

		Yes	No
a.	Convulsions, paralysis or stroke, fainting attacks, severe headaches, disease of the brain or nervous system	☐	☐
b.	High blood pressure, high cholesterol, 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 or respiratory system (if asthma, please complete Asthma Questionnaire)	☐	☐
d.	Duodenal or gastric ulcer, hernia, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas or gallbladder	☐	☐
e.	Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder to the bladder, kidney or genitourinary 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 or lymph glands, cyst, tumor or cancer	☐	☐
i.	Disorder of the eyes, ears, nose or throat	☐	☐
j.	Cold Sores on lips or face in past five years (if YES, please complete Cold Sore Questionnaire)	☐	☐
k.	Allergies, anemia or other disorder of the blood (if Allergies, complete Allergy Questionnaire)	☐	☐
l.	Any eating disorder	☐	☐
m.	Significant weight fluctuation (more than (10) pounds) in the past year (other than pregnancy) or participated in any diet programs	☐	☐
n.	Excessive use of alcohol or drugs, or use of tobacco in any form	☐	☐

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	Yes	No
o. Use of LSD, Heroin, Cocaine or any other narcotic, depressant, stimulant or psychedelic drug, whether or not prescribed by a physician in the last three (3) years	☐	☐
p. Exposure to any infection or contagious disease in the last twenty one (21) days	☐	☐
q. Under a doctor's care, for any physical or mental condition, during the past five (5) years	☐	☐
r. Surgical advice or treatment or hospitalization during the past five (5) years	☐	☐
s. Phobias, or 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 six (6) months taken any medicine or health treatments	☐	☐

For any YES answers above, please provide details on diagnosis, treatment, results, dates of disability, degree of recovery and name and address of attending physician:

_____

_____

_____

_____

_____

_____

	Yes	No
3. Have you missed any time on any production or tour in the last (3) years?	☐	☐

If YES, please confirm the following:

a. Production/Tour Title: _____

b. # of days Missed: _____

c. Cause of Absence: _____

	Yes	No
4. To be completed when the examinee is female:		
a. Have you had any disorder of menstruation, pregnancy or of any of the female organs or breasts?	☐	☐
b. To the best of your knowledge are you now pregnant?	☐	☐
If YES, how many weeks?: _____		
c. How many pregnancies have you had? _____ Have there been any complications?	☐	☐

If YES, please describe: _____

5. Name, address and telephone number of your personal physician: _____

_____

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6. When were you last examined: _____

   Why? _____

7. How often do you have a full physical exam? _____

	Yes	No
8. To the best of your knowledge and belief, are you in good health and free from physical impairment or disease?	☐	☐

   If NO, give full details: _____

9. If under the age of nine (9), please advise what childhood diseases you have had, and attach a copy of your immunization record(s):

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Part 2 – General Information

1. Please indicate all roles or responsibilities that you will have in this production:

☐ Leading Actor ☐ Supporting Actor ☐ Cameo ☐ Director ☐ Director of Photography

☐ Executive Producer ☐ Co-Producer ☐ Producer ☐ Writer ☐

☐ Other (specify) _____

2. a) Will you be performing any physical activities that require practice or training? **Yes** ☐ **No** ☐

If YES, please describe these activities and how you will be trained for them:

_____

_____

_____

b) Will you be performing your own stunts? **Yes** ☐ **No** ☐

If YES, please describe the stunts and how you will be trained for them:

_____

_____

3. Will you participate in any physical activities or sports during pre-production or principal photography of this production? If YES, please specify: **Yes** ☐ **No** ☐

Activity	Frequency (Daily, Weekly, Monthly, etc.)	Activity	Frequency (Daily, Weekly, Monthly, etc.)
☐ Auto Racing		☐ Mountain Climbing	
☐ Motorcycle Riding and/or Racing		☐ Scuba Diving	
☐ Ballooning		☐ Sky Diving	
☐ Gliding and/or Flying		☐ Downhill Skiing	
☐ Martial Arts		☐ Other (specify):	
☐ Equestrian Activities			

4. Are you now or will you at any time during this production be involved in any other production, stage representation or other professional engagement? **Yes** ☐ **No** ☐

If YES, please provide the following details:

Type of engagement: _____ Your role: _____

Dates you will be participating in this other engagement: _____

In this other engagement will you be performing any physical activities that require practice or training or that involves stunts? **Yes** ☐ **No** ☐

If YES, please describe the activities or stunts, and how you will be trained for them:

_____

_____

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	Yes	No
5. 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 Cast Insurance, Non-Appearance Insurance, or Accident, or Health or Life Insurance? If YES, please provide full details in a separate addendum.	☐	☐
6. a) Do you have any contractual provisions stating the maximum number of hours per week, per day or days per week you work?	☐	☐
b) Do you have a stop date (e.g., a termination date contained in your performance contract) in your contract?	☐	☐
If YES, please confirm stop date: _____		
7. Do you have any immediate family members (defined as mother, father, sister, brother (includes all step-relatives), spouse (includes significant other living in the same household), children (includes step-children) grandparents, grandchildren) currently suffering from a life threatening sickness or injury that could cause you to become unavailable to work at any time during the production?	☐	☐
If YES, please explain: _____		

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 statement made by me. I understand that an insurance policy may be issued and claim settlements made based upon the representations and facts stated by me as true. In the event an insurance policy is issued and a claim is paid, I understand that the Insurer will hold me fully and personally 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 Insurer's doctor in the event a claim is made.

I authorize any physician, practitioner, hospital, clinic, laboratory, other medical facility or health care provider, insurance or reinsurance company having information regarding diagnosis, treatment and prognosis of any medical or mental condition to permit the Chubb Group of Insurance Companies or its duly authorized representative to review and 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 the Chubb Group of Insurance Companies for underwriting and claim settlement purposes. I agree that this authorization for release of medical information shall be valid for thirty (30) months from its issue date. I understand that I may obtain a copy of this authorization if I so request it.

I understand that it may be necessary for my medical information to be disclosed to the insurance broker acting on behalf of the production company and that such insurance broker may disclose such information to the production company, and I hereby authorize and consent to all such disclosure.

_____ _____

Applicant Signature Date

_____ _____

Guardian Signature Date

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Physical Examination (To be completed by Physician)

General Appearance: _____ Height: _____ Weight: _____ Temperature: _____

Blood Pressure: _____ Pulse: _____ EENT: _____ Heart: _____

Lungs: _____ Abdomen: _____ Back: _____ Face: _____

Note: The Cast Insurance Supplemental Medical Report must also be completed in the following cases:

1. **Applicant is an Essential Element**
2. **Extended Pre-Production Cast Insurance or any long-term engagement is required for**
3. **the Applicant**
4. **Applicant is 65 years and older**
5. **The insurance company requests additional tests**

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 artist in his/her replies in the first part of this form with notes on examination and any abnormal findings and recommendations:

_____

_____

_____

_____

_____

_____

_____

Physician's Comments

I have today examined the above named artist/performer and in my opinion he/she is ☐ is not ☐ in sound health and free from disease and is in a fit condition, subject to any qualifications mentioned above, to fulfill his/her production/performance/engagement.

A Supplemental Medical Report was performed and is attached hereto. ☐ Yes ☐ No

I have/have not performed a Cast Medical Exam on this applicant prior to today ☐ Have ☐ Have not

Physician Signature: _____ Date: _____

A Copy Of This Form Shall Be Considered As Valid As The Original

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Cold Sore Questionnaire

Artist: _____ Production Company: _____ Production Title: _____

If you suffer from Cold Sores, please answer the following questions:

	Yes	No
1. Do you currently have a cold sore?	☐	☐

2. How long ago did you have your last cold sore? _____
3. How often to you get cold sores? _____
4. How long do your cold sores last? _____

	Yes	No
5. Do you take any medication for your cold sores?	☐	☐

If YES, what medication?

6. Do you take your medication at the onset of the cold sore or prior to principal photography? _____

If prior to principal photography how far in advance?: _____

7. If medication is prescribed, please provide confirmation of compliance to the prescription:

_____

8. What is your role in the film? _____

	Yes	No
9. Are you involved in any kissing or hugging scenes?	☐	☐

10. When do you start working on the production? _____
11. How long do you work on the production? _____

Signature of Artist or Legal Guardian: _____ Date (DD/MM/YYYY): _____

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Allergy Questionnaire

Artist: _____ Production Company: _____ Production Title: _____

If you suffer from Allergies, please answer the following questions:

1. What allergies do you suffer from? _____
2. Are your allergies seasonal? If so, please advise the time period you are affected: _____
3. Do you take any medication (or carry an inhaler) to ward off an attack? If so, please advise what precautions you take:

   _____
4. If you have an allergic reaction how are you affected? (e.g., skin rash, lack of breath, runny nose, etc.):

   _____
5. When you have an allergic reaction, how long does it typically last? _____
6. Have you had an allergic reaction within the following time frames?

	Yes	No
1. Past 30 days?	☐	☐
2. Past 6 months?	☐	☐
3. Past 12 months?	☐	☐
4. Past 3 years?	☐	☐
5. Past 5 years?	☐	☐

If you answered YES to any of the above, please specify what allergen you reacted to and explain the reaction and length of time involved:

_____

_____

_____

Signature of Artist or Legal Guardian: _____ Date (DD/MM/YYYY): _____

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Asthma Questionnaire

Artist: _____ Production Company: _____ Production Title: _____

If you suffer from Asthma, please answer the following questions:

1. How long have you had asthma? _____
2. What are the triggers? _____
3. How often do you have asthma attacks? _____
4. a) What medications do you take and how often? _____

   b) Is the treatment preventative or on as needed basis? _____

   c) Does the course of treatment seem to control the condition? _____
5. Are you compliant with treatment? _____

	Yes	No
6. Have you ever been hospitalized or taken to the emergency room for this condition?	☐	☐
7. Do you take any precautionary steps to control asthma? (e.g., Flu Shots, etc.)	☐	☐

If YES, please explain: _____

_____

_____

Signature of Artist or Legal Guardian: _____ Date (DD/MM/YYYY): _____

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Medication Warranty

Artist: _____ Production Company: _____ Production Title: _____

I, _____, confirm that I am currently taking the following medication(s) prescribed for the condition(s) below by the physician(s) indicated below:

_____ for: _____ prescribed by: _____

_____ for: _____ prescribed by: _____

_____ for: _____ prescribed by: _____

I Declare and Affirm that I am the person named on this form. During the period of time for which I am participating in the above production, I will continue to take any medication(s) or follow any course of treatment currently prescribed to me, and I will not take any prescription medication(s) other than listed above.

I Understand that an insurance policy may be issued and claim settlements made based upon the representations and facts stated by me as true. In the event an insurance policy is issued and a claim is paid, I understand that the Insurer 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.

Signature of Artist or Legal Guardian: _____ Date (DD/MM/YYYY): _____

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Hazardous Activity Warranty

Artist: _____

Production Company: _____

Production Title: _____

I, _____, contracted to participate in the production named above, hereby agree that I will not participate in any of the hazardous activities listed below.

Hazardous activity is an activity which potentially increases the risk of injury to me which could in turn cause an interruption or postponement of the production's shooting schedule.

Hazardous activity includes, but is not limited to, activities such as:

- Ballooning, hang- gliding, parasailing, riding in an ultra-light, sky-diving, bungee jumping
- Automobile racing, motorcycle riding and/or racing, boat racing, or any other type of racing, whether or not as a sanctioned competition
- Surfing, scuba diving, water skiing, hunting, roller skating, skateboarding, equestrian activity, downhill skiing/snowboarding, ice skating
- Participation in an athletic competition or contact sport, whether individually or as part of a team

I DECLARE AND AFFIRM that I am the person named on this form.

I UNDERSTAND that an insurance policy may be issued and claim settlements made based upon the representations and facts stated by me as true. In the event an insurance policy is issued and a claim is paid, I understand that the Insurer will hold me fully and personably liable and will seek recoupment from me or my estate 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.

Signature of Artist or Legal Guardian: _____ Date (DD/MM/YYYY): _____