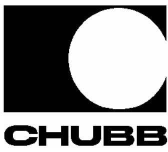

CHUBB CUSTOM MARKET, INC.
55 Water Street, New York, NY 10041
555 S. Flower St, Los Angeles, CA 90071
Fax # 212/ 612-4692 New York
Fax # 213/ 612-5721 Los Angeles

CAST INSURANCE
MEDICAL CERTIFICATE

**PRODUCTION COMPANY:** ______________________

**PRODUCTION TITLE:** ______________________

**NAME OF APPLICANT:** ______________________

**APPLICANT'S FIRST DAY OF PRINCIPAL PHOTOGRAPHY:** ______________________

**DATE/TIME OF EXAM:** ______________________
**LOCATION:** ______________________
**PHYSICIAN:** ______________________
**(Please Print)**
**ADDRESS:** ______________________
______________________
______________________
**TELEPHONE NO.:** ______________________
**FAX NO.:** ______________________

ESTIMATED WEEKS WORKING ON PRODUCTION:

## CERTIFICATE OF EXAMINED PERSON

**It is mandatory that the applicant answer the following questions**

1. Birth Date________________ Height______ Weight______ Age______ Sex ______
   Mo. Day Year

2. If you have ever had, been advised you had, been treated for, or consulted a doctor regarding any of the following medical conditions, please check the appropriate item and give full details in the space provided.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Convulsions, paralysis or stroke, fainting attacks; severe headaches, disease of the brain or nervous system |
| ☐ | ☐ | High blood pressure, heart attack, pain in chest, or any other disorder of the heart or blood vessels |
| ☐ | ☐ | Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs or respiratory system |
| ☐ | ☐ | Duodenal or gastric ulcer, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder, or hernia |
| ☐ | ☐ | Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder to the bladder, kidney or genito-urinary system |
| ☐ | ☐ | Diabetes, gout or any disease or abnormality of the thyroid or other glands |
| ☐ | ☐ | Any disease, disorder or injury of the bones, joints, muscles, back, spine or neck |
| ☐ | ☐ | Disorder of the skin, lymph glands, cyst, tumor or cancer |
| ☐ | ☐ | Disorder of eyes, ears, nose or throat |
| ☐ | ☐ | Cold Sores on lips or face in past five years |
| ☐ | ☐ | Allergies, anemia or other disorder of the blood |
| ☐ | ☐ | Any eating disorder |
| ☐ | ☐ | Significant (more than ten pounds) change of weight in the past year (other than pregnancy) or participated in any diet programs |
| ☐ | ☐ | Excessive use of alcohol or drugs, use of tobacco in any form or |
| ☐ | ☐ | Used LSD, Heroin, Cocaine or any other narcotic, depressant, stimulant or psychedelic whether or not prescribed by a physician in the last 3 years |
| ☐ | ☐ | Been exposed to any infection or contagious disease in the last 21 days |
| ☐ | ☐ | Under a doctor's care, for any physical or mental condition, during the past 5 years |
| ☐ | ☐ | Had surgical advice or treatment or been confined to a hospital during the past 5 years |
| ☐ | ☐ | 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 |
| ☐ | ☐ | Now taking or in the past 30 days taken any medicine or health treatments |

All “Yes” answers require a description of diagnosis, treatment, results, dates of disability, degree of recovery, name and address of attending physician:

______________________
______________________
______________________

3. **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? ☐ Yes ☐ No
   b. To the best of your knowledge are you now pregnant? ☐ Yes ☐ No If so, how many months? ________
   c. How many pregnancies have you had? ________ Any complications? ☐ Yes ☐ No

   Please provide details to any "Yes" answers above:

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4. **If you have you missed any time on any production or tour in the last 3 years, please give details.**
   a. Production Title: ______________________________ b. Tour ______ ____________________
   c. Days Missed: ____________________ d. Cause of Absence:
   ____________________________________________________________________________________

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 any Cast Insurance, Non-Appearance Insurance, or Accident, or Health or Life Insurance? ☐Yes ☐ No
   Details: ____________________________________________________________________________

6. Name of your personal physician: ________________________________________________
   b. Phone number: ________________________________________________
   c. Address: ________________________________________________

7. When were you last examined? _________________ Why? ______________________________________________

8. How often do you have a full physical exam?___________________________________________________________

9. To the best of your knowledge and belief are you in good health and free from physical impairment or disease? ☐ Yes ☐ No If "no" give full details:
   ____________________________________________________________________________________
   ____________________________________________________________________________________

10. Are you now or will you at any time during the period of production be in any other film, stage or other professional engagement? ☐ Yes ☐ No Please provide full particulars and dates: __________________________
    ____________________________________________________________________________________

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

12. During the period of your engagement for the production, will you participate in any physical activities or sports during your personal time? ☐ No ☐ Yes If yes, give details:
    ☐Auto Racing ☐Ballooning ☐Gliding/Flying ☐Motorcycle Riding/Racing
    ☐Equestrian Activities ☐Marathons/Triathlons ☐Skiing ☐Sky Diving
    ☐Scuba Diving ☐Mountain Climbing ☐Others: ________________________________________

13. 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:____________________________

14. Will you be performing any special physical activities that require practice or training? ☐ Yes ☐ No
    Please provide details: ____________________________________________________________________________

15. Will you be performing your own stunts? ☐ Yes ☐ No Please provide details:
    ____________________________________________________________________________________

16. Do you have any contractual provisions stating the maximum number of hours per week, per day or days per week to work? ☐ No ☐ Yes If yes, please indicate _______Hours per day ________Days per week.

17. Do you have a stop date in your contract? ☐ No ☐ Yes If yes, please indicate stop date ____________________

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Additional Comments:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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 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. 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 until a Cast claim relating to the examinee has been settled and closed with the Insured 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 authorization if I so request it.

______________________________ ______________________
***Signature of Applicant*** ***DATE***

______________________________ ______________________ ______________________
***Guardian Signature*** ***Relationship*** ***DATE***

*****PLEASE NOTE A SIGNATURE AND DATE MUST BE COMPLETED ABOVE IN ORDER FOR COVERAGE TO BE CONSIDERED***

***TO BE COMPLETED BY DOCTOR***

PHYSICAL EXAMINATION

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. ***The Applicant is over the age of 65.***
2. ***Essential Element Cast Insurance is required for the Applicant.***
3. ***Extended Pre-Production Cast Insurance or any long-term engagement is required for the Applicant.***
4. ***The insurance company requests additional tests.***

***PHYSICIAN'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 artist in his/her 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*** 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

**Signature/Qualification of Physician:** ________________________________________ **Date:** ________