

Motorsport Personal Accident & Illness Insurance Proposal Form



Proposer (if other than person to be Insured)	
Name:	
Address:	

Person to be Insured			
Name:			
Address:			
Phone:		Email:	
Date of Birth:		Height:	Weight:
Sanctioning Body:		Team:	
Occupation:			

What is your gross contracted salary, exclusive of bonuses this year:

What is your gross contracted salary, exclusive of bonuses last year:

Is any portion of your contracted salary payable to you whilst you are unable to work due to injury or sickness?
If 'Yes' please supply a copy of the contract

Yes

No

Have you had any accident, sickness, disability or life insurance declined, cancelled, renewal declined or special terms imposed?

Yes

No

If 'Yes' please provide full details:

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Benefits Requested:	Sum Insured:
Accidental Death:	
Permanent Total Disablement (by accident & illness):	
Temporary Total Disablement (by accident & illness):	(Weekly)
Medical Expenses (following accident & illness):	(Non Medicare)

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Please confirm your racing activities for the next twelve months:

(Please note any racing that is not included here will not be covered)

Do you wish to be covered for the following risks which are NOT covered unless specifically agreed and endorsed on the policy? Please tick 'Yes' or 'No'

Type:	Yes:	No:
Winter Sports?		
Are competitions to be included?		
Skin/Scuba Diving involving the use of breathing apparatus?		
Rock Climbing or Mountaineering normally involving the use of ropes or guides?		
Potholing?		
Hang-gliding, Parachuting or base jumping?		
Horseback riding or Hunting?		
Motor Cycles, Motor Scooters or quad bikes? If 'Yes', state C.C		
Air Travel other than as a passenger?		
Any other occupation, sport, pastime or activity which is likely to involve extra risk of accident?		

If you have ticked any of the boxes 'Yes' please provide full details:

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Personal Medical Details

Does the sanctioning body in whose events you participate require annual medical exams?

Yes ☐ No ☐

If 'Yes' please advise:
When was your last such exam?

Did the sanctioning body issue you a licence or permission without restrictions?

Yes ☐ No ☐

If 'No' please supply full details:

Are you currently free of injury, disease or discomfort and active in your sport? If 'No' please supply full details:

Yes ☐ No ☐

Injury Type:	
Date of Injury:	
Left or Right Side:	
Expected date of full fitness:	
Is surgery required?	
– If yes please provide full details:	

Have there been during the last five years more than 14 consecutive days, where had there been a sporting event, you would have been unfit to compete in your sport due to injury, disease or discomfort?

Yes ☐ No ☐

Have you during the last two years taken a course of pain reducing or anti-inflammatory medication exceeding 14 days?

Yes ☐ No ☐

Have you been advised or do you have any reason to believe that you may need medical treatment or undergo surgery in the future?

Yes ☐ No ☐

If 'Yes' please supply full details, including date(s) and treatment(s):

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Personal Medical Details Continued

Have you during the last two years consulted a physician or other medical care provider? If 'Yes' please supply full details, including date(s) and treatment(s):

Yes ☐

No ☐

Have you during the last five years suffered concussion?

Yes ☐

No ☐

If 'Yes' please supply full details, including date(s), grade of concussion and treatment(s):

Grade 1 – Mild, no loss of consciousness, Grade 2 – Moderate, loss of consciousness, Grade 3 – Severe, loss of consciousness greater than five minutes

Have you ever suffered or had any treatment for any of the following injuries or conditions or body parts?

Pelvis/Hips? Yes ☐ No ☐

Thigh? Yes ☐ No ☐ Right ☐ Left ☐

Knee? Yes ☐ No ☐ Right ☐ Left ☐

Ankle? Yes ☐ No ☐ Right ☐ Left ☐

Foot? Yes ☐ No ☐ Right ☐ Left ☐

Neck? Yes ☐ No ☐

Thoracic spine? Yes ☐ No ☐

Lumbar spine? Yes ☐ No ☐

Hand? Yes ☐ No ☐ Right ☐ Left ☐

Arm? Yes ☐ No ☐ Right ☐ Left ☐

Shoulder? Yes ☐ No ☐ Right ☐ Left ☐

Achilles tendonitis? Yes ☐ No ☐ Right ☐ Left ☐

Patellar tendonitis? Yes ☐ No ☐ Right ☐ Left ☐

Head injuries? Yes ☐ No ☐

Arthritis/Osteoarthritis? Yes ☐ No ☐

If you have ticked any of the 'Yes' answers, please give details below including dates, if you have been disabled, for how long and have any operations been performed.

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Personal Medical Details Continued

Have you ever shown indications of, suffered from, been treated for, or been prescribed medication for any of the following?

Heart, Chest, Circulatory System and Respiratory System? **Yes** ☐ **No** ☐

Stomach, intestines, bowel, rectum, gallbladder, or other digestive disorder? **Yes** ☐ **No** ☐

Blood Pressure? **Yes** ☐ **No** ☐

Diabetes, Anaemia or any disease or disorder of the blood or lymphatic system? **Yes** ☐ **No** ☐

Nervous System or fits? **Yes** ☐ **No** ☐

Mental, nervous or emotional disorder? **Yes** ☐ **No** ☐

Rheumatism, Arthritis, Gout ? **Yes** ☐ **No** ☐

Hernia? **Yes** ☐ **No** ☐

Dizziness or fainting? **Yes** ☐ **No** ☐

Reproductive system or sexually transmitted disease? **Yes** ☐ **No** ☐

Abnormal laboratory results in blood or urine analysis? **Yes** ☐ **No** ☐

Cancer, tumor or cyst? **Yes** ☐ **No** ☐

Persistent fever, persistent diarrhoea, night sweats or chills? **Yes** ☐ **No** ☐

If 'Yes' please supply full details, including date(s) and treatment:

Have you had any other operations or suffered any other accident or sickness? **Yes** ☐ **No** ☐

Do you or have you suffered from any other medical condition not mentioned in this proposal form? **Yes** ☐ **No** ☐

If 'Yes' please supply full details, including date(s) and treatment:

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Declaration

Declaration to be read, signed and dated by the person to be insured:

I hereby warrant that all the answers and statements contained are full, complete and true and have been correctly recorded. I have taken care not to make any misrepresentation in providing this information and understand that all information provided is relevant to the assessment and acceptance of this insurance, the terms on which it is accepted and premium charged. I agree that if any information has been given by any person other than myself on my behalf that person is my agent for that purpose.

I understand that the insurer will determine their terms and conditions upon the information provided in connection with this proposal, and I further understand that no cover is in force until this insurance proposal is accepted by the Insurer and the premium is paid. The Insurer reserves the right to decline any insurance proposal or to offer different premium and terms from those quoted dependent on the information I have provided.

Signature of person to be Insured:	
Date:	

Medical Authorisation to be read, signed and dated by the person to be insured:

By signing below, I authorise any licensed doctor, medical practitioner, osteopath, chiropractor, clinic, hospital, home health care centre, insurance company, medical information bureau, medically related facility, organisation, or other person or institution that has any records or knowledge of me or my health, to give to Insurers or an affiliate, medical consultant, or outside claims reviewers, any such information and to testify as to such information.

I understand that the information obtained by the entities outlined herein will be used to determine my eligibility for insurance benefits under the policy for which this application is being submitted. A photocopy of this form will be considered as valid as the original to release any medical information. I understand I may request a copy of this form. This authorisation will remain valid for thirty six months from the date shown below.

Signature of person to be Insured:	
Date:	