MOTORSPORTS PROPOSAL FORM

Please answer every question fully and correctly in ink. This form may be completed by the person to be insured or on his/her behalf by designated agent.

1. Name and address in full of the proposer (If other than the person to be insured, i.e., agent, representative, etc.)

____

____

Relationship to the insured ____

PLEASE PRINT THE ANSWERS TO ALL THE FOLLOWING QUESTIONS. THESE QUESTIONS RELATE TO THE PERSON TO BE INSURED.

2. Personal Information

Name in full ____

Address ____
Home/Work

____

Telephone No. ________________________ Fax No. ______________________________

Email:_________________________Citizenship ____ Social Security No. ____________

Date of birth________________________Height __________ Weight ______________

Marital Status ______ No. of Children_____ Smoker or Non-smoker_____________

Occupation____

3. Please give full details of all motor racing activities, which you expect or intend to participate in during the period of insurance:

Series______________________________Team__________________________

Full season?_________________________________If not, how many races______________

Any private testing days? ______________________Any one-off's?_______________

Number of seasons raced at this level?_______________

Other experience: ____

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Desired period of insurance ___________________through_____________________

Average annual earning in the past 3 years derived from profession or occupation including all sources:

____

Estimated earnings for the next 12 months:

____

4. Please indicate benefits requested

Life insurance_________________________

Permanent Total Disablement Lump Sum Requested: __________________________

Temporary Total Disablement ______________________________per week

Medical Coverage___________________

5. Please answer all questions as completely as possible. If no, please give details below.

Are you currently free from injury and active in your sport? ______Yes _______No

Are you now, and have you been perfectly well and in sound health for a year preceding this application? ______Yes _______No
If no, please give details: ____

____

Have you consulted a doctor during the past two years other than routine pre-post season or annual exams? _______No _______Yes
If yes, please give details: ____

____

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Have you, during the last 12 months, missed more than 3 consecutive weeks or 6 weeks in total due to injury or illness? _______No _______Yes

If yes, please give details: ____

____

6. Have you even been treated for or ever had any indication of the following, please give details to yes answers on the lines below:

AIDS (Acquired Immune Deficiency Syndrome), ARC, AIDS related Complex, or any other immunological disorder? _______No _______Yes

Cirrhosis of the liver? _______No _______ Yes

Kidney disease of any kind? _______No _______ Yes

Cancer, cyst, tumor enlarge glands, goiter, or any thyroid disorder, anemia, allergies or any disorder of the blood? ________No________Yes

Bone, Joint or other deformities? ________No ________Yes

Bleeding disorder, excessive bruising or blood in the urine? ________No ________Yes

Any disorder of the eyes, ears, nose, mouth, skin or throat or venereal disease? _________No_______ Yes

Details of Yes answers____

____

7. ***Please give details to any yes answers below:***

Are you now or have you ever been treated for drug or alcohol abuse?

__________No ______Yes

Have you during the past 5 years had any operation or suffered from illness or accident, which caused you to miss more than 3 weeks of your regular occupation or 6 weeks in total per year? __________No ______Yes

Have you any reason to think that you may need to undergo a surgical operation in the future? __________No _____ Yes

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8. Do you engage in any of the following activities?

Piloting an aircraft? ______No ______Yes. If yes, please give full details including:

Number of hours this year ________________
Number of hours next year _______________

Type of Aircraft (s) ______________________

Skydiving or hand-gliding _________No______Yes

Scuba diving _________No______Yes

Snow or water skiing _________No ______Yes

Any other activity, which may be considered dangerous? _________No______ Yes

If yes, please give details: ____

9. Do you currently have disability coverage in force? _________No______Yes

If yes, please give details: ____

10. Do you currently have medical hospitalization coverage in force? ____No ___ Yes.
If yes, please give details: ____________________________

____

I hereby warrant that all the answers and statements contained herein are full, complete and true and have been correctly recorded and, I have not withheld any information which is calculated to influence the decision of the Underwriter/Insurer and, that I understand that Certificate/Document of Insurance, subject to the terms and conditions of such Certificate/Document of Insurance will be issued on the basis of, and in consideration of, the application.

Signature of proposed insured ____

Date ____

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Authorization

I authorize any physician, health professional, hospital, or medical care facility, to give to THE GORSLINE COMPANY any information it has about me, and my health, to determine eligibility for this insurance. This authorization will be valid for a period of two years from the date signed. I am aware I have the right to receive a photocopy of this authorization and that my photocopy will be as valid as the original.

Signature of the proposed insured ____

Date : ____

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1. In the event of an emergency, please notify:

Name ____

Address ____

____

Relationship to the insured / Telephone:
____

2. Family physician

Name ____

Address ____

____

Telephone numbers ____

3. Other information

Religion ____________________________ Native language _________________________

Blood Type ____________________________