Intact Insurance Company

MEDICAL CERTIFICATE

AFFIDAVIT OF EXAMINED PERSON

Name of Examinee:

Date of Exam:

Production Title:

Examinee's Role:

Production Company:

If Actor: ☐ Leading ☐ Supporting ☐ Cameo ☐ Director

Production Type: ☐ Feature ☐ Series ☐ Other

☐ Producer ☐ DOP ☐ Other

Production Period:

Number Of Work Days:

It is mandatory that the examinee answer the following. Failure to do so may result in declination or delay of insurance coverage:

1. Date Of Birth: Age: Sex:

2. Please *check* the applicable letter if you have ever had, been advised you had, been treated for or consulted a doctor regarding any of the following medical conditions

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

   B. High blood pressure, heart attack, chest pain, irregular rhythm, angina pectoris, or any other disorders of the heart or blood vessels.

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

   D. Duodenal or gastric ulcer, colitis, rectal bleeding, jaundice 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 of the bladder, kidney, disorders of genitourinary system.

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

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

   H. Cold sores on lips or face in the past five years.

   I. Any significant change of weight, (10 lbs. or more, other than pregnancy) in the past year.

   J. Treatment for or any indication of excessive use of alcohol or drugs in any form.

   K. Any disorder of the eyes, ears, nose or throat; chronic rhinitis, frequent cold or upper respiratory infections, hayfever or allergies

   L. Any mental health conditions including but not limited to depression, phobias, eating disorders, anxiety attacks.

   M. Disorder of skin, lymph glands, cyst, shingles, tumor or cancer.

   N. Anemia or any other disorder of the blood.

Please provide details regarding any checked items per question 2: including all diagnoses, treatments, dates, results, degree of recovery, name and phone number of treating physician, and any other comments you would like to make:

3. To be completed if artist is female:
   Have you had any disorder of menstruation, pregnancy or of the female organs or breasts? ☐ YES ☐ NO
   To the best of your knowledge, are you now pregnant? ☐ YES ☐ NO If yes, how many months?
   Expected Due Date: How many pregnancies have you had?
   Any complications?
   Name and Number of OB/GYN:

4. In the past five years have you been under a doctor's care and/or been admitted to a hospital or treatment center for any physical or mental condition? ☐ YES ☐ NO
   If yes, please state:

5. Are there any other conditions, medical or otherwise, that might affect your ability to perform your duties on this production:
   ☐ YES ☐ NO
   If yes, please state:

6. To the best of your knowledge and belief, are you in good health and free from physical impairment or disease?
   ☐ YES ☐ NO
   If no, please explain:

7. When did you last receive a complete physical examination?
   What were the results?

8. Name and address of your personal physician:

9. Have you, within the past five years, been disabled as a result of any illness or injury while working in any film or stage production? ☐ YES ☐ NO
   If yes, state full particulars, name of the production and dates:

10. Are you now, or will you at any time during the period of this production, be taking part in any other film or stage production or other professional engagement? ☐ YES ☐ NO
    If yes, state full particulars and dates:

11. Will you be performing any special physical activities in this production or any production noted in (10) above (e.g. running, climbing, weapon work, fight sequences, aerial, etc.)? ☐ YES ☐ NO
    If yes, please explain:

12. Are you currently using or in the last twelve months have you used:

    A. Prescription or non-prescription drugs? ☐ YES ☐ NO

    B. Narcotics, depressants, anti-depressants, stimulants or psychedelic drugs (such as LSD), heroin or cocaine, whether prescribed by a physician or not: ☐ YES ☐ NO
       Please explain any “Yes” answer under A or B above:

    C. Tobacco? ☐ YES ☐ NO Amount/Frequency

    D. Alcohol? ☐ YES ☐ NO Amount/Frequency

13. Will you be participating in any potentially hazardous activities or sports in your personal time during preproduction or principal photography of this film, including, but not limited to, auto/motorcycle racing, equestrian, gliding/ flying/ skydiving, mountain climbing, scuba diving, snow or water skiing, or other (Please specify). ☐ YES ☐ NO
    If yes, please state frequency (daily, weekly, etc.)

14. 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, Health or Life Insurance? ☐ YES ☐ NO
If yes, please explain:

15. Do you have a stop date in your contract? ☐ YES ☐ NO If yes, please indicate stop date:

16. In what location will you be filming?
Please indicate vaccinations taken for filming in any foreign locations:

AFFIDAVIT AND AUTHORIZATION TO RELEASE INFORMATION

I declare and affirm that I am the person first named above; that the statements made hereon by me are true, correct and complete; and that I have withheld no information known to me which might alter or otherwise conflict with the statements made by me.

I understand that an insurance policy may be issued based on the statement made hereon by me. If a policy is issued and a claim is paid thereunder, I understand that the insurer will hold me personally liable and seek recoupment from me or my estate if it is thereafter determined that the statements I made hereon are not true, correct and otherwise complete, or that I have withheld information known to me which might alter or otherwise conflict with the statements I have made.

I also agree to cooperate with any claim investigation and to be re-examined by the insurer's doctors, in the event a claim is made.

I further authorize any physician, licensed practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, or production company having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me to give to Intact Insurance Company, and their affiliates, agents or brokers for underwriting and claim settlement purposes. I know that I may request a copy of this authorization. I agree that this authorization shall be valid for a period of two years from the date on which it was signed or until a Cast claim relating to me has been resolved. I also consent to the release of any information gathered by Intact Insurance Company to any production company, which may be considering me for a role.

SIGNATURE OF EXAMINEE OR LEGAL GUARDIAN (Including Relationship to Examinee) **Date Signed**

MEDICATION WARRANTY

(To be completed by the person named above)

I CONFIRM THAT I am currently taking the following medication(s) prescribed for the condition(s) below by the physician(s) indicated below:

for as Prescribed

by: *

for as Prescribed

by: *

for as Prescribed

by: *

*** Please include name and city of prescribing physician(s) (or phone numbers, if available)**

I DECLARE AND AFFIRM that I am the person named above and 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 prescribed to me.

I UNDERSTAND that an insurance policy may be issued to the Production Company based upon the above representation.

In the event that a claim is paid relating to the above and it is determined later that the above representation was not followed, **Intact Insurance Company**, and its affiliates will seek recoupment from me or my estate for such payment.

SIGNATURE OF EXAMINEE

Print Name of Examinee Date

GUARDIAN SIGNATURE/RELATIONSHIP

Print Name Date

PHYSICIAN'S EXAMINATION

Name of Examining Physician:

Physician's Telephone Number: Physician's Fax Number:

ARTIST'S GENERAL APPEARANCE

HEIGHT:	WEIGHT:	TEMP:	BP:
PULSE:	EENT:	HEART:	LUNGS:
ABDOMEN:	BACK:	LEVEL OF PHYSICAL CONDITIONING:	

If examinee is under the age of nine, please advise what childhood disease(s) he/she has had and provide immunization records:

Please provide details regarding any circled items per question 2, items A through N, or any YES answer for questions 3 through 17 on the examinee's Medical Certificate; including any abnormal findings and recommendations:

I have 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.

SIGNATURE OF PHYSICIAN **DATE SIGNED**