KEU
UNDERWRITING MANAGERS

MEDICAL CERTIFICATE

NAME OF PRODUCTION COMPANY: _____ NO PERFORMANCE DAYS: _____

NAME OF INSURED PERSON: _____ DATE OF EXAM: _____

WILL YOU BE A CAST ☐ OR CREW ☐ MEMBER LOCATION OF EXAM: _____

NATIONALITY OF EXAMINEE: _____ PHYSICIAN: (Please Print) _____

AFFIDAVIT OF EXAMINED PERSON

It is mandatory that the examinee answer the following:

1) Birth Date _____/_____/_____ Age: _____ Sex: _____
Month Date Year

2) Have you, to the best of your knowledge and belief, ever had or have reasons to know you had:	Yes	No
A. Convulsions, paralysis or stroke, severe headaches or disease of the brain or nervous system.	☐	☐
B. High blood pressure, heart attack, angina pectoris 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.	☐	☐
D. Duodenal or gastric ulcer 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 of the bladder, kidney, or Genito-urinary 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 or spine.	☐	☐
H. In the past five years, cold sores on lips or face?	☐	☐
I. In the past year, any significant change in weight?	☐	☐
J. Been treated for or had any indication of excessive use of alcohol or drugs?	☐	☐
K. Disorder of eyes, ears, nose, or throat	☐	☐
L. Allergies, anaemia, or other disorder of the blood	☐	☐
M. During the past 21 days have you been exposed to any infection or contagious diseases?	☐	☐
N. Have you consulted a doctor, been under a doctor's care, had surgical? Advice or treatment or been confined to a hospital during the past 5 years?	☐	☐
O. Have you ever been treated for any Depression, Anxiety, Bi-Polar or? Similar conditions	☐	☐

3) FEMALES Yes No
A. Are you now pregnant? ☐ ☐
B. Have you ever had any disease of the breasts, Uterus, tubes, or ovaries? ☐ ☐

ALL PERSONS TO ANSWER QUESTIONS 4 & 5

4) When did you last receive a complete medical?

_____

What were the results?

_____

Name and Address of Physician?

_____

5) Have you, within the past three years, been disabled because of any illness while working In any film or stage production? If you have, state full particulars, the name of the production and dates:

_____

_____

_____

For "yes" answers (2) and (3B), give diagnosis, treatment, results, dates of disability, degree of recovery, Name and Address of attending physician.

_____

_____

_____

6) 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?
State full particulars and dates:

_____

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

If "No", give full details:

_____

_____

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8) Please list all medication currently taken and reason for each: (Please submit a separate list if needed)

_____

I declare and affirm that I am the person first named above; 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 otherwise conflict with the statements made by me. I understand that an insurance policy may be issued based on the statements made hereon by me. If a policy is issued and a claim is paid thereunder I understand that the insurer will seek recoupment from me 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, the insurer will hold me personally liable and will seek recoupment from me for such payment. I also agree to be re-examined by the insurer's selected physician in the event a claim is made.

_____
Signature of Examinee

PHYSICAL EXAMINATION

General Appearance _____ HT. _____ WT _____ TEMP _____ B.P. _____ PULSE _____

EENT _____ HEART _____ LUNGS _____

ANY ABNORMAL PHYSICAL FINDINGS or GENERAL NOTES BY THE PHYSICIAN

_____

_____

_____

_____

_____
Signature of Physician

I authorise any physician, licensed practitioner, hospital, clinic, 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 provide to Centriq Insurance Company Limited, KEU Underwriting Managers or its legal representative, any and all such information.

I understand the information will be used by Centriq Insurance Company Limited, KEU Underwriting Managers, and their affiliates, agents, or brokers for underwriting and claim settlement purposes. I know that I may request a copy of this authorisation.
I agree that this authorization shall be valid for a period of two years from the date on which it was signed.

I also consent to the release of any information gathered by Centriq Insurance Company, KEU Underwriting Managers and their affiliates to any production company which may be considering me for a role.

☐ I consent to Centriq, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract. For further information please read our Privacy Notice, which can be found on www.centriq.co.za

PLEASE SIGN TO CONFIRM CONSENT

DATE: _____

SIGNATURE OF INSURED PERSON:
_____

NAME: _____

PHYSICAL ADDRESS:
_____

_____

WITNESS TO SIGNATURE: _____

CITY: _____

PARENTS / GUARDIAN CONSENT IF NOMINATED PERSON IS YOUNGER THAN 18 YEARS

SIGNATURE OF LEGAL GUARDIAN OR PARENT FOR PERSON IF THEY ARE YOUNGER THAN 18 YEARS:

NAME OF LEGAL GUARDIAN / PARENT: _____

SIGNATURE: _____

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DETAILS OF BROKER:

BROKER'S COMPANY NAME: _____

NAME OF BROKER (INDIVIDUAL): _____

E-MAIL ADDRESS: _____

TELEPHONE NUMBER: _____