Name, first name(s)

Application for Professional Athlete Disability Insurance

and/or

Daily Hospital Benefits Insurance

Name, first name(s)

Application and Proposal Form

Professional Athlete Disability Insurance

Daily Hospital Benefits Insurance

1. Assured / Applicant

Name, first name(s)			
Street and number		**ZIP Code**	**Place of residence**
Date of birth	**Nationality**	**Type of sport**	**Playing position**
E-mail	**Tel. no.**	**Mobile number**	**Employer / Club**

2. Insured Person

(only to be completed, if different from the Assured)

Name, first name(s)			
Street and number		**ZIP Code**	**Place of residence**
Date of birth	**Nationality**	**Type of sport**	**Playing position**
E-mail	**Tel. no.**	**Mobile number**	**Employer / Club**

3. Period of Insurance

(the contract ends upon its expiry without cancellation being required)
The maximum period of insurance is 3 years or with effect from the end of the contract of the sportsperson, whichever case may be first.

Commencement of insurance	Expiry of insurance
- 00.00.00 hrs.	- 23.59.59 hrs.

Name, first name(s)

4. Direct Debit Authorization

According to the agreed payment method, Kiln Europe S.A. shall herewith be authorised to directly debit the amounts from the after-mentioned account.

Banking institution	BIC	Account no.	Signature

5. Intermediary

Name	Address

6. Insurance Coverage

A. Professional Athlete Disability Insurance

☐ Permanent total disability (PTT) through accident and/or illness

☐ Accidental Death

☐ Death by illness (except for accidental death)

Extensions to Coverage (please tick off, where required)

	Disability	Acc. Death
Including terrorism, riots, etc.	☐	☐
Including suicide, self-inflicted injury	☐	☐
Including alcohol	☐	☐
Including HIV (Aids)	☐	☐

Premium Payment (Direct debit from bank for private insurances essential)

The premiums are to be paid as follows:

☐ **Yearly** ☐ **Half-yearly (+3%)** ☐ **Quarterly (+5%)** ☐ **Monthly (+ 7%)**

Name, first name(s)

Sums Insured

Permanent total disability (PTT)	**EUR**
Accidental death	**EUR**
Death by illness	**EUR**

Insurance Premium Insurance tax not applicable for private individuals with domicile and professional occupation in the FRG)

	Disability	Death (accident)	Death (illness)
Premium rate p.a.:	€	€	€
Additional premium (period of contract) p.a.:	€	€	€
Additional premium (extension to cover) p a.:	€	€	€
Insurance tax (19%) p. a.:	€	€	€
Total premium p.a.:	€	€	€

Premium pursuant to payment method:	€	€	€

Total premium pursuant to payment method:	**EUR**

B. Professional Athlete Disability Insurance

☐ Commencement of benefit on day 31
☐ Commencement of benefit on day 43
☐ Commencement of benefit on day 91

Maximum Duration of Benefit

☐ 52 weeks
☐ 104 weeks (20 % extra premium)

Name, first name(s)

Extension to Coverage (please tick off, where required)

- ☐ Including terrorism, riots, etc.
- ☐ Including suicide, self-inflicted injury
- ☐ Including alcohol
- ☐ Including HIV (Aids)

Premium Payment (Direct debit from bank for private insurances essential)

The premiums should be paid as follows:

☐ **Yearly** ☐ **Half-yearly (+3%)** ☐ **Quarterly (+5%)** ☐ **Monthly (+ 7%)**

Sums Insured (per day)

	EUR

Insurance Premium

Insurance tax not applicable for private individuals with domicile and professional occupation in the FRG)

	Disability	Death (accident)	Death (illness)
Premium rate p.a.:	€	€	€
Additional premium (period of contract) p.a.:	€	€	€
Additional premium (extension to cover) p a.:	€	€	€
Insurance tax (19%) p. a.:	€	€	€
Total premium p.a.:	€	€	€

Premium pursuant to payment method:	€	€	€

Total premium pursuant to payment method:	**EUR**

Name, first name(s)

The Assured undertakes to answer the after-mentioned questions in the proposal form completely and truthfully. Insofar reference is made to the final declaration prior to the signing of the form. Every change in the health condition of the sportsperson to be insured is to be subsequently disclosed even after the application is made and until the insurance contract is finally concluded. Breaches against this duty to disclose shall entitle the insurer to withdraw from or avoid the insurance contract.
The insurance contract is based upon newest version of the insurance terms and conditions of Kiln Group.

General Questions

1.	Since when have you been under contract with your present club?	
2.	When does your present contract expire?	
3.	What was your gross income in the last year?	
4.	What is your guaranteed gross income (base pay, extra allowances/bonuses) for the current season?	
5.	Beneficiary: a. Death b. Death c. Daily hospital benefit	_____ _____ _____
6.	Name and address of the attending physician	_____ _____ _____

Name, first name(s)

7.	Do you have other accident or professional athlete disability insurances, or do you intend to conclude such insurances? If so, please state a. Insurance company b. Sums insured c. Expiry date of the contract	_____ _____ _____

Health Questions

1.	Are you currently free from any injuries, illnesses or ailments, and are you actively participating in the training and sports activities? **If "NO", please give detailed information (if necessary on a separate sheet):**	**YES** **NO**

2.	During the past 2 years, do you have missed more than 5 consecutive matches due to injury, illness or ailments? **If "YES", please give detailed information (if necessary on a separate sheet):** • Type of injury / illness: _____ • Date of injury / illness: _____ • Number of matches missed: _____ • Date or recovery: _____	**YES** **NO**

Name, first name(s)

3.	Have you ever had injuries, illnesses or ailments, have you been treated or have you undergone surgery in connection with the after-mentioned areas? Please state respectively in your answers as to whether the right or left side was affected, as well as the date of the event and of the physical recovery.				

a)	Heart, chest, circulation and respiratory system	**YES** **NO**	b)	Blood pressure or diabetes	**YES** **NO**
c)	Nervous system or seizures	**YES** **NO**	d)	Rheumatism or arthritis	**YES** **NO**
e)	Groin, pelvis and hips	**YES** **NO**	f)	Eyes, nose, ears or throat	**YES** **NO**
g)	Head or cerebral concussion	**YES** **NO**	h)	Neck or spinal column	**YES** **NO**
i)	Thighs	**YES** **NO**	j)	Knee joints	**YES** **NO**
k)	Lower legs, ankle joints or feet	**YES** **NO**	l)	Achilles tendons	**YES** **NO**
m)	Shoulders or arms	**YES** **NO**	n)	Hands, wrist joints or fingers	**YES** **NO**

If you have ticked a box with "YES" and the space for the answer is not sufficient, please add on a separate sheet:

Name, first name(s)

4.	**Special agreements** (require written confirmation by the insurer)	**YES**
		NO

5.	During the last 12 months have you had special X-ray examinations such as MRT, CT, etc.? If **"YES"**, please state the date, the type of examination, the reason and the results.	**YES**
		NO

6.	Have you ever had other surgical operations or other accidents / illnesses for which you have undergone medical treatment, or have you had other medical ailments, which have not yet been disclosed in this proposal form? If **"YES"**, please state the date, the type of examination, the reason and the results.	**YES**
		NO

7.	**Acknowledgement of receipt**	
	I herewith acknowledge receipt of the terms and conditions of contract, including the information sheets and documents compliant with the VVG (Insurance Contract Act). According to the consumer information given to me I am informed about my right to revocation, any breach of the duty to disclose and the declaration on release from confidentiality obligation.	**YES**
		NO

Date	Signature

Final declaration and declaration on release from confidentiality obligation.

I declare that the afore-mentioned information has been provided to the best of my knowledge and belief and that it is true and complete, irrespective of whether or not the information has been given personally or through an informed third party. It has been made absolutely clear to me that the withholding or false representation of a material circumstance will entitle the insurers to withdraw from the insurance contract or to rescind the contract on the grounds of malicious deceit (a material circumstance is a fact which is likely to influence the insurer's decision to accept the insurance or the assessment by the insurer of the answers given in the above proposal from; if there is any doubt as to whether or not a circumstance is material within this definition, it must be disclosed).

I understand that the insurers will declare their acceptance on the grounds of the information provided in the above proposal form. For the purpose thereof, the insurers will reserve the right to reject the application or to accept the same subject to certain exclusions resulting from the above answers to the health questions. The

Name, first name(s)

insurer shall not be obligated to accept this application and reserves the right to insert personal exclusions for injuries or illnesses on the grounds of the disclosed information.
For the assessment of the duty to perform it may be necessary for us to verify the information submitted by you for proof of claim or resulting from any submitted documents (e.g. reports on medical results, medical certificates, medical expertise) or notifications, for example from a hospital or physician. This verification under inclusion of health data will only be effected insofar as there is any reason to do so (e.g. questions on diagnosis or course of treatment).

Thus, you shall consent to the release from the medical confidentiality obligation to the following extent:

For the purpose of verifying the duty to indemnify I shall herewith release medical doctors, nursing staff, staff members of hospitals, other medical institutions, nursing homes, personal insurers, statutory health insurers as well as of workers' compensation insurers and public authorities mentioned in the submitted documents or involved in the curative treatment from their confidentiality obligation, namely for up to 5 years after the contract conclusion. I shall release the staff members of the insurer from their confidentiality obligation, insofar as the collected health data are transmitted to the extent required for the assessment of the entitlement to benefit to external or medical experts in advisory capacity for the insurer, to an insurance company or also to reinsurers.

Prior to the collection of data you will be notified according the above paragraphs and your possibility to object will be indicated to you.

This declaration of the assessment of the duty to indemnify will also be valid beyond my death and will be binding accordingly for my heirs.

Place and Date | Signature of the Assured/Applicant

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