ERM Entertainment Risk Management

2nd Floor, 71 Fenchurch Street
London, EC3N 4BS
Tel: 020 7553 5979
Website: www.entertainmentriskmanagement.co.uk

2018-CAST STATEMENT OF HEALTH FORM

Name of Declared Artist _____ Height: _____

Sex _____ Age _____ Weight: _____

Production Company/Insured _____

Production Title _____

Artist's first day of Principal Photography _____ Role: _____

Estimate working time on production _____

AFFIDAVIT

I declare and affirm that I am the person named above, that the statements made by me on the pages of this Declaration of Health are true, correct and complete, and that I have not withheld information known to me which might alter or otherwise conflict with the statements made by me on this Declaration of Health. I further understand that insurance coverage may be granted and a policy of insurance may be issued based upon the representations and facts as stated in this Declaration of Health. In the event a policy of insurance is issued and a claim is paid pursuant to the policy, and it is determined that the facts set forth in this Declaration are not true, the Insurer would seek recoupment from me or my estate for such payment and hold me or my estate personally responsible for same. I further agree to cooperate with any claim investigation and to be examined by Insurer's doctors in the event a claim is made.

I also declare and affirm that during the period of this production, I will continue to take any medications or follow any course of treatment currently prescribed to me by my personal physician(s) as indicated on this Declaration of Health.

AUTHORISATION TO RELEASE INFORMATION

I hereby direct, authorise, and request any physician, medical practitioner, hospital, clinic, laboratory, health care provider, or Insurance Company, having information regarding diagnosis, treatment and prognosis of any medical or mental condition to permit Entertainment Risk Management Ltd, the Insurer, or their duly authorised representatives, to review and copy all medical reports, X-rays, charts and other data in their possession or control that pertain in any manner to my medical history, physical or mental condition care and/or treatment. I understand that the information obtained is to be used for the purpose of underwriting and claim settlement purposes. I agree that this authorisation shall be valid for twenty four (24) months from the date on which it was signed.

A COPY OF THIS AUTHORISATION SHALL BE AS VALID AS THE ORIGINAL

Signature of Artist/Guardian _____ Dated _____

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Name of Declared Artist : _____

STATEMENT OF DECLARED ARTISTS HEALTH
(It Is Mandatory That The Artist Answer All Of The Following Questions)

FOR THE FOLLOWING QUESTIONS, PLEASE EXPLAIN "YES" ANSWERS IN THE SPACE PROVIDED AT THE END OF THE SECTION

1. Name, address and phone number of your personal physician. _____

   _____

2. When were you last examined? _____ For what reason?_____

3. How often do you have a full physical exam? _____

4. **TO THE BEST OF YOUR KNOWLEDGE AND BELIEF HAVE YOU EVER HAD, BEEN ADVISED YOU HAD, BEEN TREATED FOR OR CONSULTED A DOCTOR REGARDING ANY OF THE FOLLOWING MEDICAL CONDITIONS:**

		YES	NO
A.	Convulsions, paralysis, or stroke, fainting attacks, severe headaches or disease of the brain or nervous system?	❑	❑
B.	High blood pressure, heart attack, pain in chest, or any other disorder of the heart or blood vessels?	❑	❑
C.	Tuberculosis, asthma, emphysema, persistent cough or any 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, gallbladder, or hernia?	❑	❑
E.	Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder to the bladder, kidney or genito-urinary system?	❑	❑
F.	Diabetes, elevated cholesterol, gout or any disease or abnormality of the thyroid or other glands	❑	❑
G.	Any disease, disorder or injury of the bones joints, muscles, back, spine or neck?	❑	❑
H.	Disorder of the skin, lymph glands, cyst, tumour or cancer?	❑	❑
I.	Any infection or disease of the eyes, ears, nose or throat?	❑	❑
J.	Cold sores on the lips or face in the past five years?	❑	❑
K.	Any allergies, anaemia or other disorder of the blood?	❑	❑
L.	Any eating disorder?	❑	❑
M.	Any significant (10 pounds or more) change of weight (other than pregnancy) in the last 6 months?	❑	❑
N.	Been exposed to any infection or contagious disease in the last 21 days?	❑	❑
O.	In the past 5 years have you consulted a doctor, had any surgical advice or treatment, been under a doctor's care or been confined to a hospital for any physical or mental condition.	❑	❑

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		YES	NO
P.	Suffer from any phobias or are you aware of any mental health problems that have in the past and which may prevent you from carrying out your scheduled production activities?	❑	❑
Q.	Are now taking or in the past 30 days have taken any medicine or health treatments?	❑	❑
5.	Are you currently using or in the past used:		
	A. Prescription or non-prescription drugs?	❑	❑
	B. Narcotics, depressants, cannabis or its derivatives, stimulants or psychedelic drugs (such as LSD) heroin or cocaine, whether prescribed by a physician or not?	❑	❑
	C. Tobacco? Form_____ Amount/Frequency_____	❑	❑
	D. Alcohol? Type _____ Amount/Frequency_____	❑	❑
6.	Have you missed any time on any production or tour in the past 3 years or has there been a medical condition which has caused an issue with a production and may have resulted in extra expenditure being incurred? If "yes" please provide details: Production: _____ Title: _____ Days Missed: _____ Reason: _____	❑	❑
7.	Are you now or will you at any time during the period of production be:		
	A. Employed on or performing in any other film, stage or other professional engagement? Name of Production : _____ Number of days: _____	❑	❑
	B. Involved in any stunt work?	❑	❑
8.	Will you be participating in any physical activities or sports or hazardous activity in your personal time during pre-production or principal photography of this film? If "yes" please specify frequency (daily, weekly, etc.)	❑	❑
9.	Has any Insurance Company declined to insure you or imposed any special terms in regards to your acceptance for any Cast Insurance, Non Appearance Insurance, or Accident, Health or Life Insurance?	❑	❑
10.	Will you be performing any special physical activities that require special training or practice?	❑	❑
11.	Will you be performing your own stunts?	❑	❑
12	**To the best of your knowledge and belief are you in good health and free from physical impairment or disease?**	❑	❑
13.	To be completed when the examinee is female.		
	A. Have you had any disorder of menstruation, pregnancy or the female organs or breasts?	❑	❑
	B. To the best of your knowledge are you now pregnant? If "yes", how many months? _____	❑	❑

Auto Racing _____ Motorcycle Riding/Racing _____
Ballooning _____ Mountain Climbing _____
Equestrian _____ Scuba diving _____
Gliding/Flying _____ Sky diving _____
Marathons etc. _____ Skiing (snow or water) _____
Other (specify) _____

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		YES	NO
14.	Are there any material facts relating to your personal circumstances that might affect your ability to perform your duties on this production?	❑	❑
15.	If under the age of 9, please advise what childhood diseases you have had and if all immunization shots are current. _____ _____		
16.	Please indicate your role and /or responsibilities for this production: ( ) Lead Actor ( )Supporting Actor ( )Guest Artist ( )Director ( )Director of Photography ( ) Producer ( )Exec. Producer ( ) Other (please describe) _____		
17.	If the Production is filming outside the United Kingdom have you had all recommended immunisations/vaccinations? (Please note: In the event of a claim evidence of immunisation/vaccination will be required).	❑	❑
18.	Have you ever had any dental health problems/issues? If "yes" please give details below	❑	❑

FOR ANY "YES" ANSWERS TO THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS INCLUDING DIAGNOSIS, TREATMENT, RESULTS, DATES OF DISABILITY, DEGREE OF RECOVERY, INCLUDING NAME & PHONE NUMBER FOR THE ATTENDING PHYSICIAN. (ATTACH A SEPARATE PAGE IF INSUFFICIENT SPACE)