Berkley ENTERTAINMENT
| a Berkley Company

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

In connection with the Authorization, I understand that NONE OF MY HEALTH OR MEDICAL RECORDS WILL BE OBTAINED UNLESS AS PART OF THE CAST INSURANCE UNDERWRITING PROCESS THE PRODUCTION OF SUCH RECORDS IS REQUIRED OR IF THERE IS A CLAIM MADE UNDER THE INSURANCE POLICIES issued, or to be issued by, Berkley Entertainment on behalf of Great Divide Insurance Company, Berkley National Insurance Company or Nautilus Insurance Company (hereinafter "Insurer").

I understand that this Authorization forms a part of the Cast Insurance Medical Certificate.

Completion of this document authorizes the release, disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal and State laws concerning the privacy of such information. Furthermore, I consent that my individually identifiable health information may be shared with the "insurer" in both the UK/EU and the USA for the purposes stated in section title "Authorization for release of health information" on page 1.

Details:

Your Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip: _____

Authorization for release of health information

I hereby authorize the release, disclosure and use of my health information as follows:

Persons/Organizations authorized to release the information: TREATING HOSPITALS AND PHYSICIANS, INCLUDING MY PERSONAL PHYSICIAN(S).

Persons/Organizations authorized to receive and use the information: "INSURER" AND ITS AUTHORIZED AGENTS ONLY.

Purpose of the requested disclosure or use: VERIFICATION OF ANY CAST CLAIM.

This Authorization begins when I am first named on my producer's Cast Insurance.

This Authorization shall apply to any of my health information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR pts 160,164, as amended.

Pursuant to HIPAA federal and state laws, I hereby authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to the "Insurer" and its agents, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

Important Notices

Many organizations or individuals such as hospitals, physicians, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by Federal or State confidentiality laws.

This Authorization shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

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My Rights

I understand that this Authorization is voluntary and that I may refuse to sign it. I may revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and submitted to the "Insurer" (Great Divide Insurance Company, Berkley National Insurance Company or Nautilus Insurance Company):

("Insurer")
c/o Berkley Entertainment
P.O. Box 141299
Irving, TX 75014-1299
Email: underwriting@berkleyentertainment.com
Fax: (866) 826-3862

My revocation will be effective upon receipt by "Insurer", except to the extent that "Insurer" or their authorized agents have already acted in reliance upon this Authorization.

I have the right to receive a copy of this Authorization.

Expiration

Unless otherwise revoked, this authorization expires on the completion date of principal photography or my employment by the production company, whichever is later. If no date is indicated, this Authorization will expire 12 months after the date of signing this form. However, if a claim is made concerning the person signing this Authorization, pursuant to the terms of the Cast Insurance for which this Authorization is signed, it is specifically agreed that this Authorization shall continue in force, or be reinstated so that it is valid until such time as any such claim is finally resolved.

_____ _____
Signature (patient/artist or legal representative) Date

_____ _____
Print Name Date
(If signed by someone other than the patient/artist, state your legal relationship to the patient/artist)

_____ _____
Witness Date

Return this entire document (including reverse sides of pages if you have included information on any) as follows:

Email to: underwriting@berkleyentertainment.com or **FAX** to: Entertainment Underwriting at (866) 826-3862

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CAST INSURANCE MEDICAL CERTIFICATE

Today's Date: _____

Production Company: _____

Artist's Name: _____

AFFIDAVIT AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge and agree to sign the Authorization for Release of Health Information ("Authorization") which forms part of this Certificate.

In connection with this authorization, I understand that NONE OF MY HEALTH OR MEDICAL RECORDS WILL BE OBTAINED UNLESS, AS PART OF THE CAST INSURANCE UNDERWRITING PROCESS THE PRODUCTION OF SUCH RECORDS IS REQUIRED OR IF THERE IS A CLAIM MADE UNDER THE INSURANCE POLICIES issued or to be issued by, Berkley Entertainment on behalf of Great Divide Insurance Company, Berkley National Insurance Company or Nautilus Insurance Company (hereinafter “Insurer”). Under the above conditions, I specifically authorize "Insurer" to obtain my medical records, information, and history in accordance with the Authorization. As part of the underwriting process, or if a claim is presented involving my health issues, I agree to submit to any reasonable or necessary medical examinations.

I declare and affirm that I am the person 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 above by me. I further understand that an insurance policy may be issued based upon the representations and facts stated by me above as true. I represent that I am receiving (and will continue to receive during the period of any insurance policy for this production) treatment from my personal physician, and that I will comply with the instructions of such physician as to any of the conditions listed above, including without limitation, the dosage on all medications prescribed.

I understand and agree that in the event a Claim is made under any insurance policy issued by "Insurer" in reliance upon the information provided by me in this Certificate, and a determination is made by "Insurer" that I did not provide full, complete and accurate information, that Berkley Entertainment and/or "Insurer" may seek reimbursement from me personally and individually for any amounts paid in connection with the Claim, including attorneys' fees and costs. I agree to accept personal responsibility and liability for any misinformation or omissions in connection with this Medical Certificate.

Completion of this certificate is not a guarantee that such coverage will be approved for the production company.

_____ _____

SIGNATURE OF ARTIST OR LEGAL GUARDIAN DATE

_____

PRINT NAME

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Artist's Name: _____ Birth Date: _____ Age: _____ Gender: _____

Indicate Production Type: _____ Feature Film _____ Television _____ Television Series _____ Commercial

Production Title: _____ Estimated Start Date: _____

Number of Weeks or Days schedule to work on production: _____ Weeks _____ Days

PLEASE READ THE FOLLOWING THREE (3) STATEMENTS CAREFULLY BEFORE FILLING OUT THE REST OF THIS MEDICAL CERTIFICATE.

- **IT IS MANDATORY THAT YOU TRUTHFULLY ANSWER ALL OF THE FOLLOWING QUESTIONS. IN THE EVENT OF A CLAIM, YOU MAY BE HELD PERSONALLY AND INDIVIDUALLY LIABLE AND RESPONSIBLE FOR ANY INCOMPLETE, INACCURATE OR MISINFORMATION YOU PROVIDE.**
- **THIS FORM WILL BE RETURNED IF ANY QUESTIONS ARE LEFT BLANK OR IF EXPLANATIONS ARE NOT PROVIDED WITH ANY ITEMS WITH "YES" ANSWERS.**
- **IF ADDITIONAL SPACE IS NEEDED USE THE REVERSE SIDE OF THIS FORM OR ATTACH A SEPARATE SHEET OF PAPER AND INDICATE THE QUESTION NUMBER(S) YOU ARE ANSWERING.**

For any question calling for a "Yes" or "No" answer, indicate by an "X" in the appropriate space provided.

1. Indicate all roles or responsibilities that you will have on this production:

_____ Leading Actor	_____ Supporting Actor	_____ Cameo
_____ Director	_____ Executive Producer	_____ Director of Photograph
_____ Co-Producer	_____ Line Producer	_____ Writer
_____ Other, specify _____		

If your role is that of actor, what is the name of the character(s) that you are portraying?

_____

2. Are you currently performing or scheduled to perform or participate in any other professional engagements during the period you will be rendering services for this production? YES _____ NO _____
Provide project names, dates and locations: _____
3. Do you participate in any of the following physical activities or sports during your personal or professional time? YES _____ NO _____

_____ Auto Racing	_____ Ballooning	_____ Gliding/piloting aircraft of any kind
_____ Motorcycle riding/racing	_____ Watercraft pilot	_____ Watercraft racing
_____ Skiing	_____ Marathons	_____ Mountain or rock climbing
_____ Triathlons	_____ Sky Diving	_____ Scuba Diving

4. What type of stunt activities are you either expected to or planning to take part in during your services on this project?

_____

Is there any special training or practice required for any stunts or other physical activities you are either expected to or are planning to take part in during your services on this project? YES _____ NO _____

Please provide details and period of practice or training: _____

5. Will any filming be done outside the studio (e.g. mountains, deserts, jungle, ocean, etc.)? YES _____ NO _____
6. Have you lost any time from work (including filming production or other performance activities) in the last five years due to any sort of illness, sickness, injury, surgery or other medical treatment? YES _____ NO _____
7. Have you had a significant INCREASE or DECREASE in your weight in the past two years? YES _____ NO _____

Details and dates: _____

8. Do you smoke cigarettes, cigars or use tobacco in any form? YES _____ NO _____

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Circle all of the above that apply. How much per day? _____

9. Do you drink alcohol? YES _____ NO _____

   How much and how often? _____

10. During the past five years and up to the present have you used or taken LSD, heroin, cocaine, any other narcotic, depressant, stimulant, psychedelic or other Illegal drug or substance that was not prescribed to you by a physician?
    YES _____ NO_____

    Names or types, quantity and frequency: _____

11. Are you currently using or in the last twelve months taken any prescription medications? YES _____ NO _____

    List medication(s) you are currently using: _____

    List medication(s) you have taken in the last twelve months: _____

12. Are you aware that you may have been exposed to any infection or contagious disease or virus during the last 30 days?
    YES _____ NO _____

    Details and dates: _____

13. Are you now receiving or within the last 90 days have you received, any medical or health treatments of any type (including from any doctor, specialist, chiropractor, acupuncturist, psychiatrist, therapist, etc.)? YES _____ NO _____

    Details, dates and names of treating medical professionals: _____

14. Other than care of any of the professionals stated in 13 above, have you had surgical advice or treatment or been admitted or confined to a hospital during the past five years up to present? YES _____ NO _____

    Details and dates: _____

15. When was your last complete physical examination (not including a cast exam)?

    Date of Exam: _____

    Examining Physician's Full Name: _____

    Address: _____

    Phone Number: _____

    Provide the name, address and telephone number of your personal physician (if different from the above):

    Full Name: _____

    Address: _____

    Phone Number: _____

16. Do you believe you are in good health and free from physical impairment or disease? YES _____ NO _____

    Provide details: _____

17. To your knowledge, has any insurance company declined to insure you or imposed any special terms in regard to your acceptance for Cast Insurance, Non-Appearance Insurance, Accident or Health Insurance or Life Insurance?
    YES _____ NO _____

    Details and dates: _____

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Have you ever had, or been told you have or had, any problem, condition or diagnosis relating to any of the following? For any questions calling for a "Yes" or "No" answer, please indicate by an "X" in the appropriate space provided. If Answering "Yes", you must provide details immediately below the question. If additional space is needed use the reverse side of this form or attach a separate sheet of paper and indicate the question number(s) you are answering.

18. Convulsions, paralysis or stroke, fainting attacks or disease of the brain or nervous system? YES ☐ NO ☐
Details and dates: _____

19. Severe headaches? YES ☐ NO ☐

20. High blood pressure, heart attack, pain in your chest, or any other disorder or disease of your heart or blood vessels? YES ☐ NO ☐
Details and dates: _____

21. Tuberculosis, asthma, emphysema, bronchitis, persistent cough or any other disease or abnormality of your lungs or respiratory system? YES ☐ NO ☐

22. Gastric Reflux, Barrett's Syndrome or any other condition of your esophagus? YES ☐ NO ☐
Details and dates: _____

23. Duodenal or gastric ulcer, colitis, Crohn's Disease or any other disease or abnormality of your stomach, intestines, colon or rectum? YES ☐ NO ☐
Details and dates: _____

24. Liver, pancreas, gallbladder? YES ☐ NO ☐
Details and dates: _____

25. Hernia? YES ☐ NO ☐
Details and dates: _____

26. Sugar, albumin, blood or pus in urine, kidney stones or any other condition of your bladder, kidney or genitourinary system? YES ☐ NO ☐
Details and dates: _____

27. Diabetes? YES ☐ NO ☐
Details and dates: _____

28. Gout? YES ☐ NO ☐
Details and dates: _____

29. Any disease or abnormality of your thyroid, pituitary, adrenal or any of your other glands? YES ☐ NO ☐
Details and dates: _____

30. Any injury, surgery, disease or disorder of your bones, joints, muscles, back, spine or head? YES ☐ NO ☐
Details and dates: _____

31. Any problems, disease or disorder of your eyes, ears, nose, larynx or throat? YES ☐ NO ☐
Details and dates: _____

32. Any allergies (including food allergies)? YES ☐ NO ☐
Details and dates: _____

33. Any anemia or other disorder of your blood, veins, arteries or other part of your circulatory system? YES ☐ NO ☐
Details and dates: _____

34. Any cold sores on your mouth/lips or on your face in the past two years? YES ☐ NO ☐
Details and dates: _____

35. Any disease or disorder of your skin or lymph glands? YES ☐ NO ☐
Details and dates: _____

36. Any diagnosis of or treatment for any type of cancer, tumor, mole, growth or cyst? YES ☐ NO ☐
Details and dates: _____

37. Any diagnosis of or treatment for mental health conditions including but not limited to depression, phobias, eating disorders, anxiety attacks? YES ☐ NO ☐
Details and dates: _____

38. **FEMALES ONLY:**
   a. Are you pregnant? YES ☐ NO ☐
   b. Have you ever been diagnosed or treated for any disorder or complications related to pregnancy or your breasts, uterus, ovaries or fallopian tubes? YES ☐ NO ☐
   Details and dates: _____
   Full Name of examining/treating physician: _____
   _____
   _____

39. **MALES OVER 45 ONLY:**
   a. When was your last prostate exam and PSA blood test? _____
   b. Have you ever been diagnosed or treated for any disorder or disease of your prostate gland? YES ☐ NO ☐
   Details and dates: _____
   Full Name of examining/treating physician: _____
   _____
   _____

40. **IF UNDER AGE 9:**
Advise what childhood diseases you have had and attach a copy of your immunization record.
_____
_____

NOTE: This Medical Certificate is not complete unless a completed and signed AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION is attached.

FOR INSURANCE COMPANY USE ONLY		
☐ Accepted	☐ Accepted for accident only	☐ W/O Restriction
☐ Rejected	☐ Accepted - Subject to the following conditions:	☐ With Restriction
	_____	_____
	_____	_____

PRIVACY NOTICE

Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for Insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You may have the right to review your personal information in our files and request correction of any inaccuracies. You may also have the right to request in writing that we consider extraordinary life circumstances in connection with the development of your credit score. These rights may be limited in some states. Please contact your agent or broker to learn how these rights may apply in your state or for instructions on how to submit a request to us for a more detailed description of your rights and our practices regarding personal information.

FRAUD WARNING

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CA

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree) *. *Applies in FL Only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The applicant represents that the above statements and facts are true and that no material facts have been suppressed or misstated.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part hereof.