Cast medical

Please print

Details

Your full name	
Production company	
Production	
Role in production	
Number of days filming	
Doctor	
Date of exam	

Section one

To be completed by the cast member to be insured:

Date of birth	Day:		Month:	Year:	
Age		Sex			

Medical history

		Yes	No
1.	Have you, to the best of your knowledge and belief, ever had or have reasons to know you had:		
a.	fits, paralysis or a stroke, severe headaches or disease of the brain or nervous system?	☐	☐
b.	high blood pressure, heart attack, angina pectoris, raised blood cholesterol 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, rectal bleeding, jaundice or any other disease 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, kidneys, genito-urinary system or any other sexually-transmitted diseases?	☐	☐
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 of weight?	☐	☐
j.	been treated for or had any indication of excessive use of alcohol or drugs?	☐	☐
k.	disorder of skin, lymph glands, glandular fever, cyst, tumour or cancer?	☐	☐
l.	disorder of eyes, ears, nose or throat?	☐	☐
m.	allergies, hayfever, anaemia or other disorder of the blood.	☐	☐
2.	Women		
a.	Are you now pregnant?	☐	☐
b.	Have you ever had any disease of the uterus, cervix or ovaries or have you had pelvic inflammatory disease?	☐	☐
c.	Have you been unable to work as a result of severe pre-menstrual syndrome or problem periods?	☐	☐

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3. Men

   a. Have you ever had any infection or enlargement of the prostate gland? ☐ ☐

4. General

   a. During the last 21 days have you, to the best of your knowledge and belief, been exposed to any infection or contagious disease? ☐ ☐

   b. Have you consulted a doctor, been under doctor's care, had surgical advice or treatment or been confined to a hospital during the past five years other than for minor complaints? ☐ ☐

5. For 'Yes' answers to questions 1-4 give diagnosis, treatment results, dates of illness and degree of recovery and name and address of attending doctor:

6. Name and address of general practitioner:

7. Have you, within the past three years, been unable to work as a result of any accident or illness? Yes ☐ No ☐

   If 'Yes', state full particulars and dates:

8. 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:

Cast medical

By signing this cast medical form you consent to Hiscox using the information we hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

Declaration

I DECLARE that I am the person named above; that the statements made by me are true and correct; 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 these statements made by me. If a policy is issued and a claim is paid I understand that the insurer may seek recoupment from me if it is determined that the statements I have made are not true and correct, or that I have withheld information known to me which might alter or otherwise conflict with these statements I have made. I also agree to be examined by the insurer's doctors in the event a claim is made.

I AUTHORISE Hiscox to have access to my medical records for underwriting and claims purposes. I acknowledge that I may request a copy of this authorisation. I agree that this authorisation shall be valid for a period of six months, or until any claim is resolved in which I am involved.

I FURTHER AUTHORISE Hiscox to use the medical information provided in this form for other productions I am engaged on, for which they provided production insurance. I agree that this authorisation shall be valid for a period of six months from the date of the medical examination.

Signature

Date / /

Please print name in capitals

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Section two

To be completed by the examining doctor:

General appearance			
Height		Weight	
Blood pressure		Pulse	
Heart			
EENT			

Lung functionality test	Satisfactory ☐	Unsatisfactory ☐
Flexibility test	Satisfactory ☐	Unsatisfactory ☐
Musculo-skeletal flexibility test	Satisfactory ☐	Unsatisfactory ☐
Abdomen examination	Satisfactory ☐	Unsatisfactory ☐
Are there any hernias present?	Yes ☐	No ☐
CNS	Satisfactory ☐	Unsatisfactory ☐

General comments

	/ /
Signature	Date

Please return the completed form to:

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