Austagencies Cinesure
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Medical Questionnaire

Film and Television Production

This is an important document, please read it carefully.

If you do not understand or if you have any questions regarding any matter in this document, including the **Important Notices**, please contact us or your insurance broker.

Important Notices

Duty of Disclosure
What you need to tell us

You must tell us anything that you know, or should know, could affect our decision to insure you and / or the terms on which we insure you. You must do this when you apply for a policy, renew your policy or when you change or reinstate your policy. When we ask you specific questions, you must answer these questions truthfully and in a way that a reasonable person in the circumstances would answer them. It is important that you understand you are answering our questions in this way for yourself and anyone else whom you want to be covered by the policy. These requirements are part of the Insurance Contracts Act 1984.

What you do NOT need to tell us

You do not need to tell us anything that:

- reduces our risk.
- is of common knowledge.
- we know, or as an insurer should know.
- we indicate that we do not want to know.

What will happen if you do not tell us

If you withhold relevant information or you do not answer our questions in the way we have described, we can reduce the amount we pay you for your claim, or we can cancel your policy. If your failure to tell us is fraudulent, or your answers are untruthful, we can treat your policy as if it never existed.

Privacy
Please be assured that Austagencies Cinesure is committed to protecting your privacy. We will only use the personal information that you and your medical practitioner provide to us to process, verify, investigate and/or evaluate this application. We will only provide personal information to our underwriters and reinsurers (and their representatives) and those we appoint to assist us with claims under the policy. We will not trade, rent or sell your personal information.

If you do not provide us with complete information, we will not be able to insure you. You can check the personal information we hold about you at any time.

For more information about our Privacy Policy, ask us for a copy.

1. Name of person: ______________________________
2. Address: ______________________________
3. Production title: ______________________________
4. Production company: ______________________________
5. Date and Place of birth: ______________________________
6. Sex: ______________________________

7. *Have you ever had, been advised you had, been treated for or consulted a doctor regarding any of the following medical conditions:*

a.	Convulsions, paralysis or stroke, fainting attacks, severe headaches or disease of the brain or nervous system ?	**Yes** ☐	**No** ☐
b.	High blood Pressure, heart attack, chest pains, or any other disorder of the heart or blood vessels ?	**Yes** ☐	**No** ☐
c.	Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs or respiratory system ?	**Yes** ☐	**No** ☐
d.	Duodenal or gastric ulcer, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder, or hernia ?	**Yes** ☐	**No** ☐
e.	Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder of the bladder, kidney or genito-urinary system ?	**Yes** ☐	**No** ☐
f.	Diabetes, gout or any disease or abnormality of the thyroid or other glands ?	**Yes** ☐	**No** ☐
g.	Any disease, disorder of injury of the bone, joints, muscles, back, spine, or neck ?	**Yes** ☐	**No** ☐
h.	Disorder of skin, lymph glands, cyst, tumour or cancer ?	**Yes** ☐	**No** ☐
i.	Disorder of eyes, ears, nose or throat ?	**Yes** ☐	**No** ☐
j.	Cold sores on lips or face in past five years ?	**Yes** ☐	**No** ☐
k.	Allergies, anaemia or other disorder of the blood ?	**Yes** ☐	**No** ☐
l.	Any mental health problems, including phobias ?	**Yes** ☐	**No** ☐
m.	Any eating disorder ?	**Yes** ☐	**No** ☐
n.	Any significant change in weight (15kg or more) in the past year ?	**Yes** ☐	**No** ☐
o.	Treatment for or any indication of excessive use of alcohol or drugs ?	**Yes** ☐	**No** ☐

8. *To be completed by female applicant only.*

a.	To the best of your knowledge are you now pregnant ?	**Yes** ☐	**No** ☐
b.	Have you had any disorder of menstruation, pregnancy, or of the female organs or breasts ?	**Yes** ☐	**No** ☐

9. In the past five years have you been under a doctor's care and/or been admitted to a hospital for any physical or mental condition ? **Yes** ☐ **No** ☐

10. Have you been exposed to any infection or contagious disease during the last twenty one days? **Yes** ☐ **No** ☐

11. Are there any other conditions, medical or ortherwise, that might affect your ability to perform your duties on this production ? **Yes** ☐ **No** ☐

12. When did you last receive a complete physcial examination ? ________________

13. What were the results ? ____

14. Name and address of personal physician: ______________________________

____

15. Do you have any beliefs that preclude you from taking prescribed medication or treatment ? **Yes** ☐ **No** ☐

16. Have you, within the past five years, been disabled as a result of any illness or injury while working in any film or stage production ? **Yes** ☐ **No** ☐

If yes, state full particulars, name of production and dates:

____

17. Are you now or will you at any time during the period of production be taking part in any other film, stage or other professional engagement? **Yes** ☐ **No** ☐

If yes, state full particulars, dates, and any hazardous activity or stunts involved:

____

18. Are you currently using or in the last five years have you used:

a. Prescription or non prescription drugs ? **Yes** ☐ **No** ☐

b. Narcotics, depressants, anti-depressants, stimulants, psychedelic drugs (such as LSD), heroin or cocaine, whether or not prescribed by a physician ? **Yes** ☐ **No** ☐

c. Tobacco ? **Yes** ☐ **No** ☐

d. Alcohol ? **Yes** ☐ **No** ☐

If yes, to any answer under 18 (a,b,c or d) above, state full details:

____

____

19. Do you have a family history of heart or kidney disease or diabetes ? **Yes** ☐ **No** ☐

If yes, state full particulars:

____

20. Will you be participating in any potentially hazardous activities, stunts or sports in your personal time during pre-production or principal photography of this production, including but not limited to, auto/motorcycle racing, equestrian, gliding / flying / skydiving, mountain climbing, scuba diving, snow or water skiing, or other (Please specify) ? **Yes** ☐ **No** ☐

    If yes, state full particulars:

    ____

21. Will you be participating in any potentially hazardous activities, stunts or sports during this production (e.g. running, climbing, weapon work, fight sequences, aerial, underwater, overwater etc.) ? **Yes** ☐ **No** ☐

    If yes, state full particulars:

    ____

22. Has any insurance company declined to insure you or imposed special terms in regard to your acceptance for any cast insurance, non appearance insurance, film producers indemnity insurance, accident, health or life insurance ? **Yes** ☐ **No** ☐

    If yes, state full particulars:

    ____

23. Will you be travelling outside Australia at any time during the production ? **Yes** ☐ **No** ☐

    If yes, state full particulars:

    ____

24. Give titles of your last three films including production company name:

    ____

    ____

    ____

25. Are your prepared to submit to medical examination by and to adhere to any reasonable medical treatment which may be prescribed by the Insurers' medical advisers ? **Yes** ☐ **No** ☐

26. Do you agree that the Insurers may obtain a medical report from your regular medical attendant or any other medical adviser whom you have consulted ? **Yes** ☐ **No** ☐

Please provide details regarding answers of YES for Questions 7 through to 23 above:

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Artistes's declaration

I declare that the above statements are true to the best of my knowledge and belief and that knowing the purpose for which the declaration is required I have not withheld any material fact and that I am in a fit state of health to fulfill my contract

Date: ____________________ Signature: ____________________

Production Company: ____________________

Production Co. Address: ____________________

Authorisation to Medical Physicians, Hospitals, Insurers & other institutions

I the undersigned, hereby direct, authorise and request and physician, practitioner, hospital, laboratory, insurance company or health provider to permit the insurer, production company, insurance intermediary, or their agents to review and copy all medical reports, x-ray, charts, records and other data in your possession or control whoch pertain in any manner to my medical history, physical condition, care and/or treatment.

You are also authorised to discuss with the insurer, production company, insurance intermediary, or their agents any such medical history, physical condition, care and/or treatment and to furnish them with a written report regarding same. This information is to be used for the purpose of processing, verifying, investigating and/or evaluating my application for insurance, a claim for insurance benefits, responsibility for payment or legal liability.

This authorisation shall be considered valid for twenty four months from its date unless sooner revoked in writing by me. A copy of authorisation shall be considered as valid as the original and I am entitled to receive a copy of this authorisation if I request.

Date: ____________________ Signature of Examinee &/or Parent/Legal Guardian (if under 18). ____________________

Production Company Declaration

I/We have read the Artiste's replies to the Questions on pages 2,3 and 4 of this form and their declaration and I/We do not know any additional information that should have been added.

I/We agree that the the Artiste's replies to the Questions on pages 2,3 and 4 of this form and their declaration be the basis of a contract between me/us and the Insurers for this Film Producers Indemnity Insurance.

Production Company: ____________________

Address: ____________________

Signature and name ____________________

Position / Title: ____________________

Date: ____________________

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Medical Report / Physicians Examination

To be completed by Medical Examiner

1. Artist Name / Examinee: ____________________
2. Height (in centimetres) ____________________
3. Weight (in kilograms) ____________________
4. What is the rate and character of the pulse ? ____________________
5. Is there evidence of arterial changes ? ____________________
6. Are there any signs of nervous disease present ? ____________________
7. Is albumen and/or sugar present in urine ? ____________________
8. Blood Pressure - if found to be in excess of 140/90 please repeat readings twice with intervals of five minutes between each while artist is at rest.

Reading	1	2	3	Comments
Systolic				
Diastolic				

9. If foreign location work involved, what innoculations do you recommend, and have they been administered ?

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____

10. Please comment on any special feature revealed by the artist in his/her medical questionnaire which notes on examination any abnormal findings and recommendations.

____

____

Medical Examiners Declaration

I have today examined the above named artist and in my opinion he/she is in sound health and free from disease and is in a fit condition, subject to any qualifications mentioned above, to fulfil his/her production commitments during the following ____________ weeks.

Name: ____________________

Address: ____________________

Qualifications: ____________________

Signature: ____________________

Date: ____________________