

APPLICATION FOR DISABILITY INSURANCE

to: **PETERSEN INTERNATIONAL UNDERWRITERS**

23929 Valencia Blvd., Suite 215, Valencia, California 91355 • (800) 345-8816

Underwritten by Certain Underwriters at Lloyd's

PART I

1. Full Name of Proposed Insured:	2 a. Sex:
3a. Occupation :	b. Date of Birth:
b. Material duties which account for the majority of your income:	c. Place of Birth:
c. Substantial duties which account for most of your work time:	
4a. Name & Address of Employer:	b. Length of service: c. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Residence Address:	
6. Send Notices to: <input type="checkbox"/> Business <input type="checkbox"/> Residence <input type="checkbox"/> Other Phone Number:	
7. Your former occupation, if changed within 2 years:	
<i>If yes is answered for any of the questions 8 through 11, give details in remarks (No. 19)</i>	
8. Is foreign travel or residence contemplated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you ever engage in hazardous sports or hobbies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you had your driver's license suspended or revoked during the past three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever had life, health or accident insurance declined, postponed, cancelled, rated or modified, or renewal or reinstatement of such refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No

12a. List below all disability insurance for which you are presently applying, have in force, or are applying to reinstate Include all individual, group, mortgage and credit plans. (If none, please indicate.)

Insurer	Disability Monthly Benefit	Disability Lump Sum	Benefit Period	Personal	Business	Premium Payor

12b. Does your employer provide any disability benefits or salary continuation benefits? If yes, provide details Yes No

13. Are you covered under a state disability program? (If yes, give full details in No. 19) Yes No

14. Personal Disability Overhead Expense Key Person
 Loan Indemnification _____
Section I (if applicable)
Monthly Benefit Requested US\$ _____
Elimination Period Requested _____ days
Benefit Period Requested _____ months
 Optional Residual Optional COLA

Section II (if applicable)

Principal Sum Requested US \$ _____
Principal Sum Elimination Period _____ months

15. Are you terminating any existing policies in order to qualify for the policy (or policies) now applied for? (If yes, give details with termination dates in Remarks, No. 21) Yes No

16. Who will pay premium on policy? _____

17. Policy Owner (if other than insured): _____

18. Loss Payee (if other than insured): _____

19. Remarks: _____

Answers to questions 20 a, b, & c are to be as reported on your 1040 USA Tax return

20. a. What were your earnings from your occupation or profession last year: (Gross income less business expenses, but before taxes) US\$ _____
b. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (circle items) US\$ _____
c. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? Is this included in 20a? Yes No US\$ _____

Documentation of figures shown in 20 (a) through (c) may be needed for underwriting or claim servicing. Such documentation may include copies of individual or business corporate income tax returns, and/or W-2.

IT IS UNDERSTOOD AND AGREED

- that all answers to the above questions, to the best of my knowledge and belief, are complete and true.
- that all answers to the above questions, together with this application, shall form the basis of the issuance of any coverage hereunder
- that in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
- the insurance hereunder applied for shall take effect on the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.

Signature of Proposed Insured

Signature of Applicant-Purchaser if not Proposed Insured

Date

080108

KeyPerson_080108

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PART II

23. a. Name and address of your personal physician (if none, please indicate): _____

 b. Date and reason you last consulted a physician, psychotherapist, psychologist or other healthcare provider: _____

 c. What treatment was given or medication prescribed? _____
 d. If the consultation was for a checkup, did symptoms, disease, illness or injury prompt the checkup? (If yes, explain in No. 28) Yes No

24. a. Your height _____ ft. _____ in. Your weight _____ lbs.	b. How much has your weight changed in the last year? <input type="checkbox"/> None <input type="checkbox"/> Gain lbs. <input type="checkbox"/> Loss lbs. _____ lbs.	c. Marital status: _____
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25. Have you, to the best of your knowledge ever been treated for or had any indication of the following?
- | | |
|---|---|
| a. Disorder of eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Headaches, fainting, unconsciousness, convulsions, concussions, paralysis, or any disorder of the brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Tuberculosis, asthma, or any disorder of the lungs or respiratory system? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Chest pain, high blood pressure, heart murmur, or any disorder of the heart, spleen, blood, blood vessels or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disorder of the digestive system including stomach, intestines or bowel, liver, rectum, appendix, or gall bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Disorder of genito-urinary system including kidneys, bladder or any other urinary disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Rheumatism, gout, arthritis or any deformity or disorder of the spine, muscles, bones or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No
h. Diabetes, disorder of the thyroid, pancreas or lymph nodes, or any disorder of the glands? <input type="checkbox"/> Yes <input type="checkbox"/> No
i. Cancer, tumor, cyst or growth? <input type="checkbox"/> Yes <input type="checkbox"/> No
j. Any allergies of any sort or disorders of the skin? <input type="checkbox"/> Yes <input type="checkbox"/> No
k. Hernia, or any disorder of the reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No
l. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
m. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told you had AIDS or ARC (AIDS related complex)? <input type="checkbox"/> Yes <input type="checkbox"/> No
n. Any physical disorder, injury, or abnormality within the last 5 years, not disclosed in the answers above (No. 25 a-m) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

- | | |
|--|--|
| 26. a. Within the last 5 years have you ever had an injury or sickness which was the basis for an insurance claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Within the last 5 years have you ever had or been advised to have a surgical operation or hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are you now taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Have you ever received treatment or joined an organization for alcoholism or drug dependence? <input type="checkbox"/> Yes <input type="checkbox"/> No
g. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other similar drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
h. Have you ever used tobacco at any time within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

27. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described above? (If "No", explain fully in Remarks No. 29) Yes No

28. Give complete details below to any questions above which are answered "yes"

Question Number	Details of Conditions or Treatment	Date and Duration	Details and Degree of Recovery	Doctors and Hospitals With addresses

29. Remarks: _____

IT IS UNDERSTOOD AND AGREED

1. that all answers to the above questions, to the best of my knowledge and belief, are complete and true.
2. that all answers to the above questions, together with this application, shall form the basis of the issuance of any coverage hereunder
3. that in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
4. the insurance hereunder applied for shall take effect on the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.

Signature of Proposed Insured

Date
080108

Signature of Applicant-Purchaser if not Proposed Insured

Petersen International Underwriters Privacy Policy Statement

Petersen International Underwriters

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

Information We Collect

We collect non-public information about you from numerous sources including, but not limited to:

- a) Information we receive from you on applications and other forms;
- b) Information about your transactions with our affiliates, others or us;
- c) Information we receive from consumer-reporting agencies; and
- d) Financial and medical sources.

Information We Disclose

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

Right to access or correct your personal information

You have a right to request access to or correction of your personal information in our possession.

Confidentiality and Security

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

Contacting Us

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: piu@piu.org



PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Boulevard, Suite 215, Valencia, California 91355

(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604

Website: <http://www.piu.org> E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

I, _____ hereby acknowledge this Authorization to Release Health
(Proposed Insured/Patient)
Related information.

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment which includes, but is not limited to:

- Physicians
- Hospitals
- Clinics
- Medically related facilities
- Rehabilitation facilities
- Laboratories
- Other/Specific: _____

____ Proposed Insured/Patient Initials

to disclose my medical records to Petersen International Underwriters (or its assigned representative including, but not limited to: Secure Image Solutions) for the purpose of insurance underwriting or claims administration. For purposes of this authorization, medical records shall include, but not be limited to:

- Patient Histories
- Progress notes
- Test results
- X-rays
- Psychiatric Evaluations
- Drug and/or Alcohol Treatment information
- HIV Test Results and/or
- Other diagnostic information

____ Proposed Insured/Patient Initials

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured/Patient

Date

Printed Name

Signature (if by someone other than the Proposed Insured/Patient)

Date

Printed Name and Relationship

I, _____ understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters
23929 Valencia Boulevard, Suite 215
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization.

This Authorization will expire 2 years after the date the Authorization is signed unless a different date is specified here: _____.

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured/Patient

Date

Printed Name

Signature (if by someone other than the Proposed Insured/Patient)

Date

Printed Name and Relationship



DISABILITY DIVISION

Keyperson Insurance Questionnaire

Name of Keyperson: First _____ Middle _____ Last _____

Occupational Duties: _____
(please be precise) _____

What does this person do that another person cannot do? _____

What financial loss would the firm suffer if this employee were disabled? _____

How long in the employment of the firm: _____

Gross salary, bonuses and commissions over last three years:
US\$ _____ US \$ _____ US\$ _____
(CURRENT) (LAST YEAR) (TWO YEARS AGO)

Firm Name: _____

Type of Business: _____ Number of Employees: _____

Is Keyperson an owner of the firm? Yes No What is % of Ownership? _____

What existing coverage is currently in force on the Keyperson in which the firm is the beneficiary of any benefits of the insurance?

Death: (Face Amount) \$ _____ Disability: \$ _____

What is the basis for selecting these amounts of insurance? _____

Net profit/loss of firm over past three years:

US\$ _____ US\$ _____ US\$ _____
(CURRENT) (LAST YEAR) (TWO YEARS AGO)

Are there other Keypersons in the firm? Yes No How many? _____ Are others to be insured? Yes No

Are you or the company a party to any legal proceeding at this time? YES NO If "yes", furnish all details. _____

Form completed by:

Name: _____ Title: _____

Signature: _____ Date: _____

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