



# DISABILITY INSURANCE SHORT FORM APPLICATION

To: PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondents

23929 Valencia Blvd., Suite 215 • Valencia, CA 91355-2186 • Tel (800) 345-8816 • Fax (661) 254-0604

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Specialty (if applicable): \_\_\_\_\_ Employer: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Premium Notice to be sent to: \_\_\_\_\_

- 1. a. What were your earnings from your 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 1a?  YES  NO US\$ \_\_\_\_\_

2. Have you consulted or been treated by a licensed physician, psychotherapist, psychologist, or other health care provider in the last 12 months, or from inception date of your current expiring coverage, whichever is longer?  YES  NO

If yes, whom did you see? \_\_\_\_\_

Address and phone number of Doctor seen \_\_\_\_\_

\_\_\_\_\_

For what were you treated by this physician or healthcare provider? \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Results from this consultation or treatment? \_\_\_\_\_

\_\_\_\_\_

If more than one physician was seen please explain on reverse side.

3. Have you received treatment or been advised to seek treatment for drug or alcohol abuse?  YES  NO

4. Have you filed a claim for disability benefits in the past 5 years?  YES  NO  
If yes, what was the nature of the accident or sickness? \_\_\_\_\_

Date disability occurred \_\_\_\_\_

Time lost from work \_\_\_\_\_

5. To the best of your knowledge, are you now in good health and free from mental or physical impairment, abnormality, injury or disease?  YES  NO

6. Has any application been made by you within the last year for accident, sickness, hospitalization, major medical or life insurance been declined, postponed or increased in rate?  YES  NO

7. Are you presently working full-time?  YES  NO

8. Are you now taking medication?  YES  NO

Meds & reason taken \_\_\_\_\_

9. Is foreign travel or residence contemplated?  YES  NO  
If yes, where? \_\_\_\_\_

10. Are you presently applying for or applying to reinstate any disability insurance other than this application?  YES  NO  
(If yes please list below, include all individual, group, mortgage and credit plans)

11. Do you have any disability insurance in force? (If yes please list below, include all individual, group, mortgage and credit plans)  YES  NO

12. Does your employer provide any disability benefits or salary continuation benefits? (If yes, please provide details below)  YES  NO

13. Are you covered under a state disability program? (If yes, please provide details below)  YES  NO

Insurer	Approximate Date of Issue	Personal Disability Monthly Benefit	Business Overhead Monthly Benefit	Buy/Sell Disability

### 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 such questions, together with this agreement and any prior underwriting information, 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 the questions on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits will be payable.
- 4. that except as amended by the answers to the above questions, any answers shown on any prior application for this coverage signed and dated by me are expressly reaffirmed.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, to give to the certain underwriters at Lloyd's of London or its legal representative any such information.

### AUTHORIZATION

Date \_\_\_\_\_

\_\_\_\_\_

Signature of Proposed Insured

\_\_\_\_\_

Signature of Applicant-Purchaser if not Proposed Insured

Phone: \_\_\_\_\_

Applicant's Fax: \_\_\_\_\_

Applicant's e-mail: \_\_\_\_\_

Is this a confidential fax?  YES  NO



**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](mailto:piu@piu.org)

**AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION**  
**This Authorization complies with the HIPAA Privacy Rule**

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I authorize** all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/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 all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, information and/or HIV Tests/Test Results, and any other pertinent medical information.

**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 refuse to sign this authorization and that such refusal to sign will not be a condition to affect the ability of the Applicant to obtain treatment. 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.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Signature of Legal Representative (if other than Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

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

# **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](mailto:piu@piu.org)