



DISABILITY INSURANCE SHORT FORM APPLICATION

PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Coverholder

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: _____

Address: _____

Email: _____ Telephone: (____) _____ - _____

Bill To: Email Applicant's Address Employer - Attention: _____

Other: _____

- 1. a. What were your earnings from you 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. Are you presently working full-time? Yes No

3. Is foreign travel or residence contemplated? Yes No
If yes, where? _____

4. Have you consulted or been treated by a licensed physician, psychotherapist, psychologist, or other health care provider from inception date of your current expiring coverage? Yes No

If yes, whom did you see? _____

Address and phone number of Doctor seen: _____

For what were you treated by this physician or health care provider? _____

Date: _____ Results from this consultation or treatment? _____

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

5. Have you received treatment or been advised to seek treatment for drug or alcohol abuse? Yes No

6. 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: _____

7. Has any application submitted by you within the last year for accident, sickness, hospitalization, major medical or life insurance been declined, postponed or increased in rate? Yes No

(If yes, please provide details.) _____

8. Are you currently taking any medication? (If yes, please provide details of medications taken.) Yes No

9. 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

10. Are you applying for, reinstating or have in force any disability insurance (including individual, group STD, group LTD, salary continuation benefits, mortgage and credit plans) other than this application? If yes, please list below. Yes No

Insurer	Approximate Date of Issue	Coverage Type	Monthly Benefit

IT IS UNDERSTOOD AND AGREED:

- 1. That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true;
- 2. That all answers on 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 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. That except as amended by the answers to the above questions, any answer 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 record 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

Signature of Insured

Signature of Applicant-Purchaser if not Insured

Date