Disability Division

Key Person Insurance Questionnaire

Name of Key Person: 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 Key Person were disabled? _____

_____

How long has this Key Person been working for the firm? _____

Gross salary, bonuses and commissions over the last three years:

US$* _____ (Current) *US$ _____ (Last Year) *US$* _____ (Two Years Ago)

Firm Name: _____

Type of Business: _____ Number of Employees: _____

Is the Key Person an owner of the firm: ❑ Yes ❑ No What is the % of ownership? _____

What existing coverage is currently in force on the Key Person 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 the firm over the past three years:

US$* _____ (Current) *US$ _____ (Last Year) *US$* _____ (Two Years Ago)

Is the Key Person or the firm a party to any legal proceeding at this time? ❑ Yes ❑ No If yes, provide details.

_____

Form completed by:

Name: _____ Title: _____

Signature: _____ Date: _____

Petersen International Underwriters

23929 Valencia Blvd, Ste 215, Valencia, CA 91355

Tel (800) 345-8816 • Fax (661) 254-0604

piu@piu.org • www.piu.org