



APPLICATION FOR DISABILITY INSURANCE

PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Coverholder

Producer #: _____ PART I.

PERSONAL INFORMATION

Applicant's Name: First _____ Middle _____ Last _____
 Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: Male Female
 Residence Address: _____
 City _____ State _____ Zip Code _____
 E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____
 Employer's Name: _____
 Employer's Address: _____
 City _____ State _____ Zip Code _____
 Occupation: _____ Daily Duties: _____
 Specialty: _____ Length of Service: _____
 Policy Owner: _____ Loss Payee: _____
 Premium Payor: Applicant Employer Other: _____
 Payment Mode: Multi-Year Prepay Annual Semi-Annual Quarterly Monthly (EFT/CC)
 Bill To: Residence Employer - Attention: _____
 Other: _____

1. Are you actively at work? Yes No

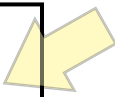
***If "Yes" is answered for any of the following questions please provide full details in the space below.
If there is not sufficient space, please attach your answers on a separate sheet.***

- 2. Is foreign travel or residence contemplated? Yes No
- 3. Has your occupation changed within the last 2 years? Yes No
- 4. Do you ever engage in hazardous sports or hobbies? Yes No
- 5. Are you a party to any legal proceeding at this time? Yes No
- 6. Are you aware of any fact that could change your occupation or financial stability? Yes No
- 7. Have you ever been convicted of any felony or misdemeanor or do you have any charges pending? Yes No
- 8. Have you or any business of which you had any ownership in filed for bankruptcy in the last 5 years? Yes No
- 9. Have you had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated? Yes No
- 10. Have you ever had life, health, or accident insurance declined, postponed, cancelled, rated, or modified, or reinstatement of such refused? Yes No

Details: _____

PLEASE INITIAL THE FOLLOWING

I have read or had read to me and understand each of the questions and statements on this entire application. _____
 No one has prevented me from spending as much time as I felt was necessary to understand this application. _____





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PART I.

FINANCIAL INFORMATION

11. What was your gross income less business expenses, but before taxes from your profession last year? US\$ _____
12. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (Circle items.) US\$ _____
13. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? Is this included in #11? Yes No US\$ _____

Please indicate the type of coverage and the amount of coverage that you are applying for.

14. Personal Overhead Expense Key Person Loan Indemnification Buy/Sell Other _____
15. **Section I — Monthly Benefits (if applicable)**

Monthly Benefit requested: _____ US\$
 Elimination Period requested: _____ Days
 Benefit Period requested: _____ Months

Section I - Optional Riders:

- Residual
 COLA
 Prime Flex (Loan Indemnification Only)
 Salary Replacement Rider (Overhead Expense Only)
 Business Revenue Replacement Rider (Key Person Only)
 Partial Disability Benefit Rider

16. **Section II — Lump Sum Benefit (if applicable)**

Principal Sum requested: _____ US\$
 Elimination Period requested: _____ Months

ADDITIONAL POLICY INFORMATION

17. Does your employer provide disability benefits or salary continuation benefits? Yes No
18. Are you terminating any existing policies in order to qualify for the policy(s) now applied for? Yes No
19. Please list all disability insurance (including individual, group, mortgage and credit plans) for which you are applying, have in force, or are reinstating. If None, please indicate None. None

Insurer	Issue Date	Personal DI Monthly Benefit	Business Overhead Monthly Benefit	Buy/Sell Disability	Other Disability

PLEASE INITIAL THE FOLLOWING

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PART II.

MEDICAL INFORMATION CONTINUED

*If "Yes" is answered for any of the following questions please provide full details in the space below.
 If there is not sufficient space, please attach your answers on a separate sheet.*

- 23. Have you used tobacco at any time within the last three years? Yes No
- 24. Has your weight increased or decreased more than 10 pounds within the last year? Yes No
- 25. Are you now taking/using prescription medication and/or nonprescription medication? Yes No
- 26. In the last 60 days, have you taken any medicines which are not listed in #25? Yes No
- 27. Within the last 5 years have you had or been advised to have a surgical operation or hospitalization? Yes No
- 28. Have you ever received or requested benefits or payments because of an injury or illness or disability? Yes No
- 29. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests? Yes No
- 30. Have you ever received treatment or joined an organization for alcoholism or drug dependence? Yes No
- 31. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness? Yes No
- 32. Within the last 5 years have you had any procedures, examination or tests recommended which have not been completed? Yes No
- 33. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other drugs? Yes No

Question #	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery	Doctors & Hospitals with Addresses

(Use additional sheets if needed)

- 34. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application? Yes No - If No, please provide details: _____

IT IS UNDERSTOOD AND AGREED:

- that all answers to the questions on this application, to the best of my knowledge and belief, are complete and true,
- that all answers on 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, and
- 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.
- I have read or had read to me and understand each of the questions and statements on this entire application.
- No one has prevented me from spending as much time as I felt was necessary to understand this application.

 Signature of Applicant Date: _____

 Signature of Policy Owner - (if not Applicant) Date: _____



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

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.*



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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