



APPLICATION FOR DISABILITY INSURANCE
PETERSEN INTERNATIONAL UNDERWRITERS

Producer #: _____ PART I.

PERSONAL INFORMATION

Applicant's Name: First _____ Middle _____ Last _____
Date of Birth: ____/____/____ Height: _____ Weight: _____ Sex: [] Male [] Female
Address: _____
City _____ State _____ Zip Code _____
E-mail: _____ Telephone (____) _____ - _____
Employer's Name: _____
Employer's Address: _____
City _____ State _____ Zip Code _____
Occupation: _____ Daily Duties: _____
Specialty: _____ Length of Service: _____
Policy Owner: _____ Loss Payee: _____
(If other than Insured) (If other than Insured)
Premium Payor: [] Applicant [] Employer [] Other: _____
Payment Mode: [] Multi-Year Prepay [] Annual [] Semi-Annual [] Quarterly [] Monthly (EFT/CC)
Bill To: [] E-mail [] Applicant's Address [] 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 disability, 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 and no one has prevented me from spending as much time as I felt was necessary to understand this application.

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION

In Compliance with HIPAA Privacy Regulation

I, the proposed insured, 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. Additionally it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. 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.

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 that I have signed this Authorization.

Printed Name of Proposed Insured

Date of Birth

Signature of Proposed Insured

Date

*Printed Name of Legal Representative (if other than Proposed Insured)

Relationship to the Proposed Insured

Signature of Legal Representative (if other than Proposed Insured)

Date

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



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