



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

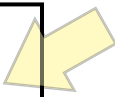
***If "Yes" is answered for any of the following questions please provide full details in the space below.
If there is not sufficient space, please attach your answers on a separate sheet.***

- 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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No one has prevented me from spending as much time as I felt was necessary to understand this application. _____



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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:

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 this application 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, and
4. 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.
5. I have read or had read to me and understand each of the questions and statements on this entire application.
6. 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.*



LIFE & DISABILITY DIVISION

Confidential Financial Statement

Proposed Insured: FIRST _____ MIDDLE _____ LAST _____

The following financial disclosure is made for the purpose of establishing insurability in connection with a pending application on myself. This is furnished as a true and accurate statement of my financial condition as of:

_____, 20__

	Column (A) CURRENT YTD 20__	Column (B) LAST YEAR 20__	Column (C) TWO YEARS AGO 20__
I. ANNUAL INCOME from occupation or profession			
Net income (after business expenses, before taxes) (Include nonpassive income from Schedule K-1)	US\$ _____	US\$ _____	US\$ _____
Commission Income	US\$ _____	US\$ _____	US\$ _____
Bonuses	US\$ _____	US\$ _____	US\$ _____
Pension & Profit Sharing Contributions	US\$ _____	US\$ _____	US\$ _____
Royalty Income	US\$ _____	US\$ _____	US\$ _____
II. OTHER INCOME			
Dividends and Interest	US\$ _____	US\$ _____	US\$ _____
Net Real Estate Income before Depreciation (Net income after expenses)	US\$ _____	US\$ _____	US\$ _____
Passive income from Schedule K-1	US\$ _____	US\$ _____	US\$ _____
Other (Please specify) _____	US\$ _____	US\$ _____	US\$ _____
_____	US\$ _____	US\$ _____	US\$ _____
III. TOTAL CURRENT NET WORTH (Please itemize below)			
Cash, Savings, Stocks, Bonds	US\$ _____		
Personal Property (e.g. furnishings, jewelry, car, boat, etc.)	US\$ _____		
Personal Residence (fair market value less mortgages, loans)	US\$ _____		
Other Real Estate (fair market value less mortgages, loans)	US\$ _____		
Business Interest (show fair market value less mortgages, loans)	US\$ _____		
Other (Please specify) _____	US\$ _____		
_____	US\$ _____		
IV. ADDITIONAL CLARIFYING INFORMATION			
V. ARE YOU A PARTY TO ANY LEGAL PROCEEDING AT THIS TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", furnish all details.			

I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

_____ Date

_____ Signature of Proposed Insured

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