



# PROFESSIONAL ATHLETES APPLICATION

LONG FORM

Send completed application and exam to:

**PETERSEN INTERNATIONAL UNDERWRITERS**

23929 Valencia Boulevard Suite 215, Valencia, CA 91355

Email: piu@piu.org • Fax: (661) 254-0604 • Telephone (800) 345-8816

## PROPOSED INSURED INFORMATION

Proposed Insured: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Gender:  Male  Female

Address: Number & Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sport: \_\_\_\_\_ Team Name: \_\_\_\_\_ Position: \_\_\_\_\_

*Wherever "YES" answer(s) require full details, please indicate in the space provided.  
If there is not sufficient space, please attach your answers on a separate sheet.*

1. Are you presently applying, have in force, or are applying to reinstate any disability insurance other than this application?  Yes  No

Insurer	Date of Issue	Monthly Benefit	Lump Sum Benefit

2. Do you have other employment on a part time or full time basis?  Yes  No
3. Do you participate in winter sports, other than skating or curling?  Yes  No
4. Do you participate in water or underwater sports?  Yes  No
5. Do you participate in rock climbing or mountaineering?  Yes  No
6. Do you participate in motor sports or motorcycling?  Yes  No
7. Do you participate in any **OTHER** activities excluded by your club contract?  Yes  No

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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*Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.*

## MEDICAL INFORMATION

8. Do you currently have an injury, illness, or any discomfort?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
9. Do you have any physical limitation(s) that keep you from performing any duties of your sport?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
10. Have you missed any playing time during the last 24 months?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
11. Within the last 24 months have you taken any pain-reducing or anti-inflammatory medication?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
12. Have you had any diagnostic tests (X-rays, MRI, etc.) in the past 2 years? (List date(s), test(s) & results)  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
13. Have you been advised, or do you have reason to believe that you may need medical treatment and/or surgery in the future? If "Yes" please provide details:  Yes  No  
\_\_\_\_\_
14. Do you have any hardware (such as pin(s), screw(s), rod(s), plates, etc.) remaining?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
15. Have you ever lost consciousness?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
16. Do you have any knowledge or suspicion of bulged or herniated discs in your back and/or neck?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
17. Have you suffered any injury, sickness or discomfort for which you have **NOT** sought medical advice, diagnosis, or treatment? If "Yes" please provide details:  Yes  No  
\_\_\_\_\_
18. Have you ever undergone hospitalization/treatment exceeding 14 days or surgery as a result of sickness or disease or a non-injury condition? If "Yes" please provide details:  Yes  No  
\_\_\_\_\_
19. Have you consulted a physician in the last 24 months **other than for routine examination(s) or physical(s)**?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_
20. Have you ever been prescribed medication, or recommended a diagnostic test, and/or surgery which have **NOT** been undertaken?:  Yes  No  
If "Yes" please provide details: \_\_\_\_\_  
\_\_\_\_\_



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*Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.*

21. Please answer the following questions and give details where appropriate. Have you ever injured, sprained, strained, dislocated, torn, suffered pain, tendonitis, discomfort, or had surgery for any of the following?:

- a. Head? (Including Concussion Or Unconsciousness)  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- b. Neck Or Cervical Spine?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- c. Right Shoulder?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- d. Left Shoulder?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- e. Chest (Including Ribs)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- f. Upper Back (Thoracic Spine)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- g. Lower Back (Lumbar Spine Including Coccyx And Tail Bone)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- h. Pelvis/Hips (Including Groin - Specify Side)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- i. Abdomen (Including Stomach)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- j. Right Arm (Including Elbow)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- k. Left Arm (Including Elbow)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- l. Right Hand (Including Wrist & Digits)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- m. Left Hand (Including Wrist & Digits)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- n. Right Thigh (Including Hamstring)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- o. Left Thigh (Including Hamstring)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- p. Right Knee?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- q. Left Knee?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- r. Right Lower Leg (Including Ankle And Achilles Tendon)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- s. Left Lower Leg (Including Ankle And Achilles Tendon)?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- t. Right Foot?  Yes  No \_\_\_\_\_  
\_\_\_\_\_
- u. Left Foot?  Yes  No \_\_\_\_\_  
\_\_\_\_\_



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*Wherever "YES" answer(s) require full details, please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.*

22. Have you ever shown indications of, suffered from, been treated for or been prescribed treatment for any of the following conditions?:

- a. Gout?  Yes  No \_\_\_\_\_
- b. Hernia(s)?  Yes  No \_\_\_\_\_
- c. Concussion(s)?  Yes  No \_\_\_\_\_
- d. Stomach or Bladder?  Yes  No \_\_\_\_\_
- e. Dizziness or Fainting?  Yes  No \_\_\_\_\_
- f. Rheumatism or Arthritis?  Yes  No \_\_\_\_\_
- g. Ears, Eyes, Nose or Throat?  Yes  No \_\_\_\_\_
- h. Blood Pressure or Diabetes?  Yes  No \_\_\_\_\_
- i. Cancer and Related Diseases?  Yes  No \_\_\_\_\_
- j. Liver, Kidneys, and/or Digestive Organs?  Yes  No \_\_\_\_\_
- k. Heart, Chest, Circulatory System, and/or Respiratory System?  Yes  No \_\_\_\_\_
- l. Nervous System, Epilepsy, Mental Disorders, Seizures, or Convulsions?  Yes  No \_\_\_\_\_
- m. Paralysis whether complete or partial regardless of length of time and duration?  Yes  No \_\_\_\_\_

23. Have you ever suffered any sickness **NOT** associated with any of the above which resulted in confinement of greater than 7 days?  Yes  No

If yes please provide details: \_\_\_\_\_

24. Any family (mother, father, sibling(s)) history of any of the condition(s) mentioned under question #22 above?  Yes  No

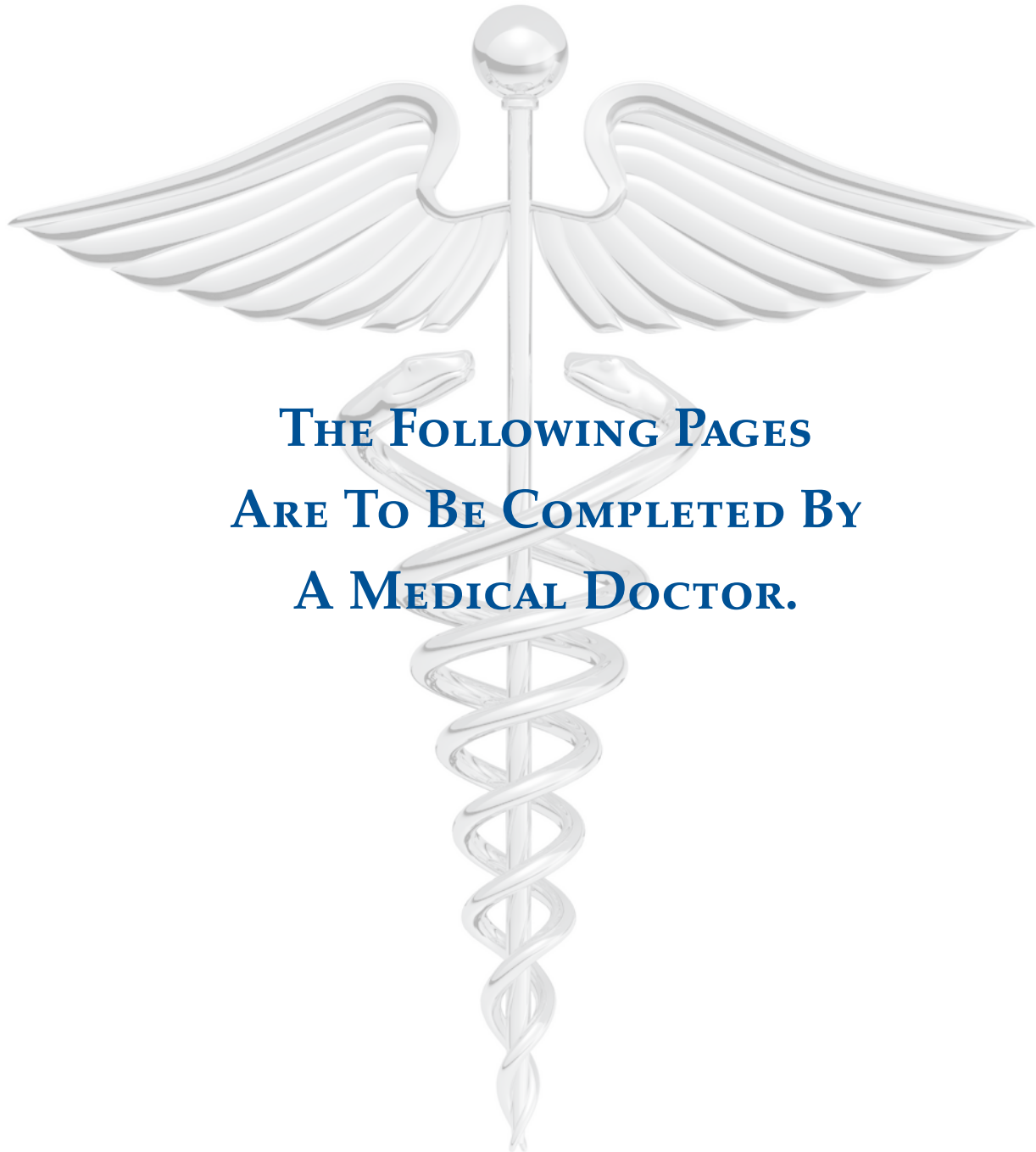
If yes please provide details: \_\_\_\_\_

## It is understood and agreed as follows:

I have read the statements and answers recorded herein. They are to the best of my knowledge and belief, true and complete and correctly recorded. Underwriters will rely on this information in making their determinations. No agent, broker or medical examiner has authority to waive the answers to any questions, to determine insurability, to waive any of the underwriter's rights or requirements, or to make or alter any contract or policy. The underwriter has the right to require medical exams and tests to determine insurability. The insurance applied for will not take effect unless the health of the Proposed Insured remains as stated in the Application on the inception date of the policy. Underwriters do not bind themselves to accept this application for insurance, and reserve the right to decline and/or impose specific exclusions as a result of information disclosed herein. The information obtained will be used to determine if the Proposed Insured is eligible for (a) the insurance requested; or (b) benefits under a policy which is in force. It will also be used for any other business purpose which relates to the insurance requested or the policy which is in force. The form will be valid for 30 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

Proposed Insured \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print



**THE FOLLOWING PAGES  
ARE TO BE COMPLETED BY  
A MEDICAL DOCTOR.**



# PROFESSIONAL ATHLETES APPLICATION

## MEDICAL DOCTOR'S REPORT FORM

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**ALL** following sections are to be completed by Doctor on examination of player

Proposed Insured: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Sport: \_\_\_\_\_ Team Name: \_\_\_\_\_ Position: \_\_\_\_\_

1. Have you examined and/or treated this patient in the past?:  Yes For \_\_\_\_\_ Years  No
2. Has the Proposed Insured suffered discomfort, injury or treatment of any kind to any of the following? Doctor to query Proposed Insured. If answered "Yes" to any of the questions, please give details including dates (day/month/year).

- |  |  |       |
|--|--|-------|
| a. Head? (Including Concussion Or Unconsciousness)           | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| b. Neck Or Cervical Spine?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| c. Right Shoulder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| d. Left Shoulder?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| e. Chest (Including Ribs)?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| f. Upper Back (Thoracic Spine)?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| g. Lower Back (Lumbar Spine Including Coccyx And Tail Bone)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| h. Pelvis/Hips (Including Groin - Specify Side)?             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| i. Abdomen (Including Stomach)?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| j. Right Arm (Including Elbow)?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| k. Left Arm (Including Elbow)?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| l. Right Hand (Including Wrist & Digits)?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| m. Left Hand (Including Wrist & Digits)?                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| n. Right Thigh (Including Hamstring)?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| o. Left Thigh (Including Hamstring)?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| p. Right Knee?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| q. Left Knee?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| r. Right Lower Leg (Including Ankle And Achilles Tendon)?    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| s. Left Lower Leg (Including Ankle And Achilles Tendon)?     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| t. Right Foot?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| u. Left Foot?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |



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## MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: \_\_\_\_\_

*If there is not sufficient space, please attach your answers on a separate sheet.*

3. Doctor to examine Proposed Insured. If exam results were not normal, please describe in detail.

### Exam Results

Normal    Abnormal

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| a. Head? (Including Concussion Or Unconsciousness)           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b. Neck Or Cervical Spine?                                   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c. Right Shoulder?   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| d. Left Shoulder?  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| e. Chest (Including Ribs)?                                   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| f. Upper Back (Thoracic Spine)?                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| g. Lower Back (Lumbar Spine Including Coccyx And Tail Bone)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| h. Pelvis/Hips (Including Groin - Specify Side)?             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| i. Abdomen (Including Stomach)?                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| j. Right Arm (Including Elbow)?                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| k. Left Arm (Including Elbow)?                               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| l. Right Hand (Including Wrist & Digits)?                    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| m. Left Hand (Including Wrist & Digits)?                     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| n. Right Thigh (Including Hamstring)?                        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| o. Left Thigh (Including Hamstring)?                         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| p. Right Knee?   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| q. Left Knee?  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| r. Right Lower Leg (Including Ankle And Achilles Tendon)?    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| s. Left Lower Leg (Including Ankle And Achilles Tendon)?     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| t. Right Foot?   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| u. Left Foot?  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |



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## MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: \_\_\_\_\_

*If there is not sufficient space, please attach your answers on a separate sheet.*

4. Please check the appropriate boxes:

	Normal	Abnormal	
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, Ears, Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulse	<input type="checkbox"/>	<input type="checkbox"/>	_____

5. Has the Proposed Insured ever lost consciousness?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_

6. Do you have any knowledge or suspicion of bulged or herniated disc(s) in the back and/or neck?  Yes  No  
If "Yes" please provide details: \_\_\_\_\_

7. Is the Proposed Insured currently taking medication(s)?  Yes  No  
If "Yes" please provide the medication and the reason being taken: \_\_\_\_\_

8. On completion of physical examination, please indicate overall impression with regard to player's ability to continue their career.  
\_\_\_\_\_  
\_\_\_\_\_

9. As a Physician, please state your relationship to the Proposed Insured, i.e., Personal Physician, Team Physician, etc?  
\_\_\_\_\_  
\_\_\_\_\_

Proposed Insureds Signature \_\_\_\_\_ Date \_\_\_\_\_

### Physician Information

Physicians Name:	First _____	Middle _____	Last _____
Address:	Number & Street _____		
	City _____	State _____	Zip Code _____
Phone Number:	_____	Fax: _____	Email: _____
Physician's Signature:	_____		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](mailto: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.*

# **Petersen International Underwriters Privacy Policy Statement**

## **Petersen International Underwriters**

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

### **Information We Collect**

We collect non-public information about you from numerous sources including, but not limited to:

- a) Information we receive from you on applications and other forms;
- b) Information about your transactions with our affiliates, others or us;
- c) Information we receive from consumer-reporting agencies; and
- d) Financial and medical sources.

### **Information We Disclose**

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

### **Right to access or correct your personal information**

You have a right to request access to or correction of your personal information in our possession.

### **Confidentiality and Security**

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

### **Contacting Us**

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: [piu@piu.org](mailto:piu@piu.org)