



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

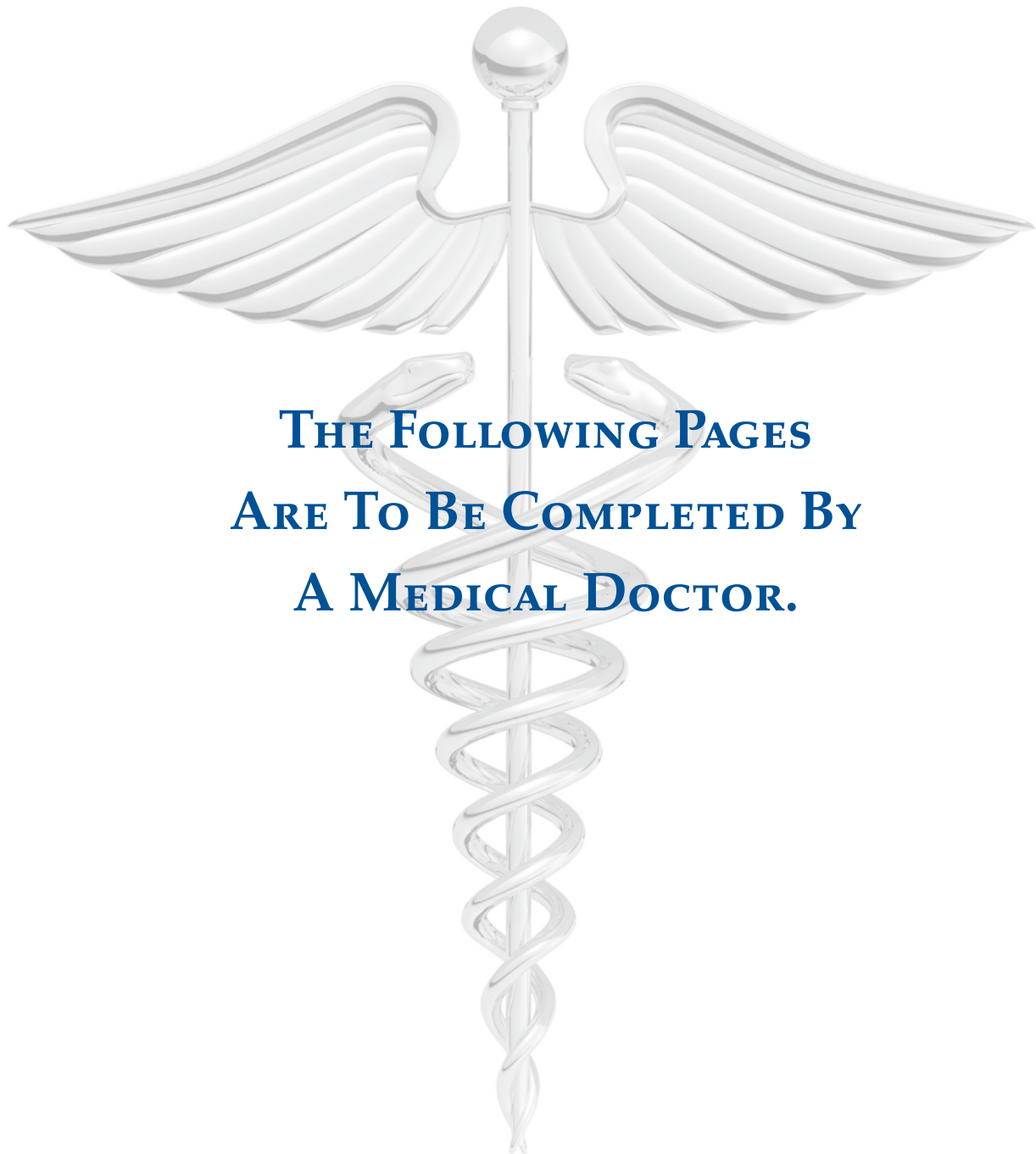
If yes please provide details: _____

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.**



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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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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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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 _____

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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