

# PROFESSIONAL ATHLETES APPLICATION

**SHORT FORM**

To: Petersen International Underwriters  
23929 Valencia Blvd., Suite 215 • Valencia, California 91355  
Telephone (800) 345-8816 • Facsimile (661) 254-0604

Name in Full: \_\_\_\_\_  
FIRST MIDDLE LAST

Residence Address: \_\_\_\_\_  
STREET AND NUMBER  
\_\_\_\_\_  
CITY STATE ZIP ( ) DAYTIME PHONE NUMBER

Personal information: \_\_\_\_\_  
DATE OF BIRTH HEIGHT WEIGHT

Occupation Details: \_\_\_\_\_  
SPORT LEAGUE  
TEAM POSITION

Earnings: \_\_\_\_\_  
(last year) OCCUPATIONAL WINNINGS/EARNINGS ENDORSEMENT INCOME

### COVERAGE APPLYING FOR:

<input type="checkbox"/> PTD (Permanent Total Disability)	<input type="checkbox"/> TTD (Temporary Total Disability)
Benefit Requested: \$ _____	Monthly Benefit Requested: \$ _____
	Benefit Period Requested: _____
	Elimination Period Requested: _____ days

### QUESTIONNAIRE

- Are you currently free of injury and illness and playing for your sport?  YES  NO
- Have you during the last 24 months missed any playing time due to injury or illness?  YES  NO  
If so, enter dates, reason(s) and total number of games missed.  
\_\_\_\_\_  
\_\_\_\_\_
- Have you any reason to think that you may need to undergo a surgical operation and/or medical treatment in the future?  YES  NO  
Give details \_\_\_\_\_
- Do you engage in any other sport(s) and/or activities other than the sport which is your primary occupation?  YES  NO  
Please give dates and for what reasons.  
\_\_\_\_\_  
\_\_\_\_\_
- Are you taking or have you taken any medication in the past 2 years?  YES  NO  
Please give dates and for what reasons  
\_\_\_\_\_  
\_\_\_\_\_
- Have you any physical defect or infirmity? Give details.  YES  NO  
\_\_\_\_\_  
\_\_\_\_\_
- Is your sight in any way impaired; have you ever suffered from any disease of the eyes? Give details.  YES  NO  
\_\_\_\_\_  
\_\_\_\_\_
- Is your hearing impaired; have you ever had any discharge from the ears? Give details.  YES  NO  
\_\_\_\_\_  
\_\_\_\_\_

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## SHORT FORM

- 9) Have you ever suffered from Appendicitis, Asthma, Blood Pressure Abnormalities, Blood-spitting, Diabetes, Dyspepsia, Fits, Gout, Hernia, Paralysis, Piles, Rheumatism, or any Rheumatic infection, Skin Infections, Varicose Veins, or any Diseases or Disorders of the Chest or Respiratory System, Heart, Stomach, Bladder or Nervous System? Give dates and state if operation performed.  YES  NO
- 10) Do you have any hardware remaining (such as pins, screws, rods, plates, etc.)?  YES  NO  
 Details \_\_\_\_\_
- 11) Have you during the past 5 years had any other operation or suffered from any other illness or accident? If so, give details and dates.  YES  NO
- 12) Have you consulted a doctor during the past 2 years? Please give dates, for what reasons, and what were the results.  YES  NO
- 13) Are you presently applying, have in force, or are applying to reinstate any **disability insurance other than this application?**  YES  NO  
**(If yes, please list below)**

Insurer	Date of issue	Monthly Benefit	Lump Sum Benefit

- 14) Have you ever made any claim for accident or illness?  YES  NO  
 If yes, please state each case as to nature of claim, date, amount and name of company or underwriter.
- 15) Have you ever been declined, or accepted on special terms, for life insurance or insurance against accident or illness?  YES  NO
- 16) Has any company or underwriter ever cancelled or declined to renew your policy? Give details.  YES  NO
- 17) Do you engage in any sport(s) as a professional other than the sport, which is your prime occupation? If so give details.  YES  NO
- 18) Are you now and have you been perfectly well and in sound health for a year preceding this application?  YES  NO

### AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, THAT HAS RECORDS OR KNOWLEDGE OF ME OR MY HEALTH, TO RELEASE SUCH DOCUMENTATION TO PETERSEN INTERNATIONAL UNDERWRITERS.

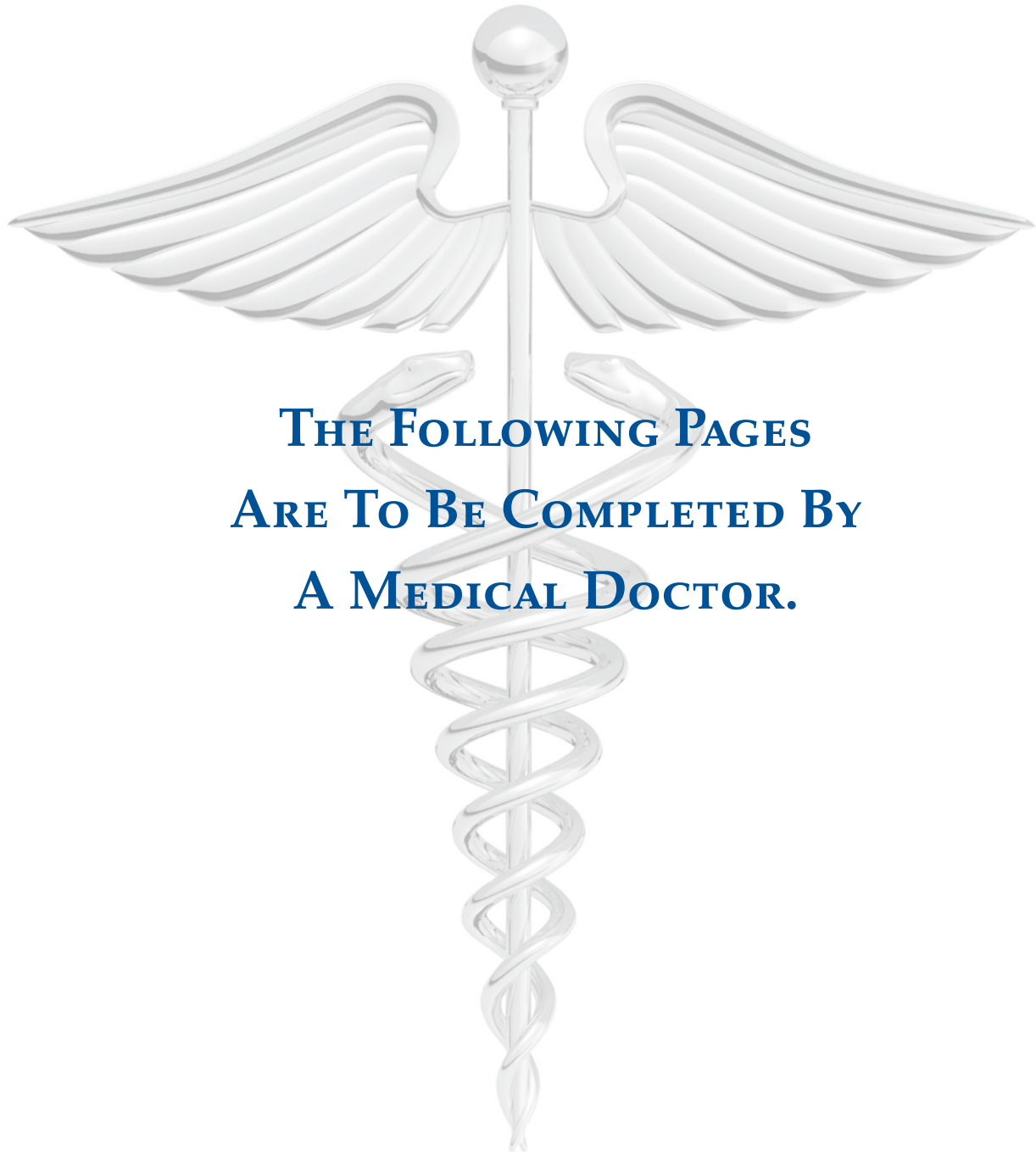
### DECLARATION

I hereby warrant that all the answers and statements herein contained are full, complete and true and have been correctly recorded and I have not withheld any information which is likely to influence the decision of the underwriter and that I am willing to accept a policy, subject to the terms and conditions of such policy, to be issued on the basis of and in consideration of the proposal.

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.

PROPOSED INSURED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF APPLICANT \_\_\_\_\_



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



# PROFESSIONAL ATHLETES APPLICATION

## MEDICAL DOCTOR'S REPORT FORM

Send completed application and exam to:

### PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Boulevard Suite 215, Valencia, CA 91355

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

**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 | _____ |



# PROFESSIONAL ATHLETES APPLICATION

## 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 _____

# 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.*



**PETERSEN**  
INTERNATIONAL UNDERWRITERS

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