

Yachting Medical Insurance



Yacht Crew

- Medical Insurance
- Medical Evacuation
- Accidental Death
- Repatriation of Remains

Complementary Plans

- Disability Insurance
- Kidnap & Ransom
- International Term Life



PETERSEN

International Underwriters

Lloyd's Coverholder

23929 Valencia Boulevard Suite 215

Valencia, California 91355-2186

Telephone 800.345.8816

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The Yachting Medical Plan Works Like This

Deductible: Choose from \$500, \$1,000, \$2,500, or \$5,000 per person, per period of year.

Coinsurance: After the Deductible is paid, Underwriters will reimburse 80% of the next \$5,000 in Eligible Expenses and then 100% up to the Maximum Benefit.

Maximum Benefit: \$5,000,000 per person per lifetime (Ages 0 through 69)

Maximum Benefit: \$500,000 per person per lifetime (Ages 70 through 74)

Coverage Eligibility

Residency Requirement: Anticipation of being outside the USA at least 5 months per year.

Renewal Requirements: Payment of renewal premium, confirmation of the above residency requirement. (Coverage is not medically underwritten on the renewal)

The Plan Benefits

Treatment may be received anywhere in the world. This coverage is secondary to medical benefits, services, or reimbursements from any other source except Medicaid. Underwriters will reimburse the Eligible Expenses incurred, listed below, when Medically Necessary for the diagnosis and treatment of an Illness or Injury, subject to the terms and limitations described in the Certificate.

- Hospital room and board.
- Hospital intensive care unit.
- Other Medically Necessary Hospital services and supplies, such as emergency room care, outpatient surgery, diagnostic services, supplies and therapy.
- Skilled Nursing Facility room and board, if confinement begins within 30 days following a Medically Necessary Hospital confinement of three days or longer.
- Home Health Care, if hospitalization would have been required if Home Health Care were not provided, and the care is provided in accordance with a written plan established and approved by a Physician
- Local area ambulance service.
- Physician services consisting of home, office, and hospital visits, and any other medical care and treatment.
- Diagnostic services, supplies, and therapy.



Annual Premiums

Age	\$500 Deductible		\$1,000 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
10-17	\$456	\$456	\$359	\$359	\$327	\$327	\$294	\$294
18-24	\$1,110	\$1,925	\$848	\$1,307	\$751	\$1,175	\$589	\$948
25-29	\$1,239	\$2,122	\$948	\$1,501	\$815	\$1,307	\$653	\$1,045
30-34	\$1,307	\$2,349	\$980	\$1,693	\$848	\$1,501	\$686	\$1,207
35-39	\$1,436	\$2,446	\$1,110	\$1,893	\$948	\$1,631	\$751	\$1,307
40-44	\$1,598	\$2,022	\$1,207	\$1,501	\$1,045	\$1,307	\$848	\$1,077
45-49	\$1,796	\$2,219	\$1,372	\$1,696	\$1,175	\$1,501	\$948	\$1,110
50-54	\$2,187	\$2,446	\$1,631	\$1,828	\$1,501	\$1,696	\$1,207	\$1,339
55-59	\$2,676	\$2,676	\$2,055	\$2,055	\$1,796	\$1,796	\$1,469	\$1,469
60-64	\$3,556	\$3,362	\$2,903	\$2,611	\$2,611	\$2,446	\$2,087	\$1,860
65-69	\$6,915	\$5,937	\$5,675	\$4,763	\$4,501	\$3,915	\$3,588	\$3,132

Additional Benefits Included

Medical Evacuation: All medically necessary expenses for stabilization and transportation to the facility nearest your home, which can provide the appropriate care up to \$100,000.

Repatriation of Remains: In the event of death, Underwriters will reimburse the cost of delivery of your remains to a mortuary nearest your home up to \$100,000.

Recreational Sports & Activities: Underwriters will reimburse you for eligible expenses which are incurred due to an injury resulting from the participation in a Hazardous Sports or Activities up to \$250,000. Covered sports and activities include scuba diving, skiing, sailing (recreational and competitive), and most other sports.



Additional Plans Available

- Kidnap & Ransom
- International Term Life
- Disability Insurance

Limitations

1. Maternity, normal delivery and/or well baby care will begin after the policy has been in force for at least 15 months, to a maximum of \$5,000 per year. Complications of pregnancy covered as any other condition after 15 months.
2. Mental and Nervous Disorders covered to \$5,000 lifetime maximum for outpatient visits. Disorders necessitating hospitalization shall be covered as any other condition.



Exclusions

- Any expense which you are not legally obligated to pay.
- Services which are not Medically Necessary and are not furnished by or under supervision of a Physician.
- Expenses for services and supplies for which you are entitled to benefits, services, or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan, or from any other source, except Medicaid.
- Expenses in excess of Usual, Customary, and Reasonable fees.
- Outpatient drugs, except following a hospitalization if prescribed for the same Illness or Injury.
- Self-inflicted injuries while sane or insane.
- Treatment for alcoholism, drug addiction, and/or allergies.
- Rest cures, quarantine, or isolation.
- Cosmetic surgery, unless necessitated by an accidental injury.
- Dental exams, dental x-rays, and general dental care except as a result of an accidental injury.
- Eye glasses or eye examinations.
- Hearing aids or hearing examinations.
- General or routine examinations.
- Pregnancy and pregnancy-related conditions including, but not limited to, fertility, pre-natal care, childbirth, miscarriage, or abortion until a minimum of 15 months has elapsed, subject to the Terms and Limitations in the Certificate.
- Injuries due to war or any act of war whether declared or undeclared. Terrorism however is included in the policy benefits.
- Injuries sustained while committing a criminal or felonious act.
- Expenses incurred for, or resulting from, pain which is not supported by medical diagnosis.
- Cataract surgery which is not considered an emergency and/or which is performed at Your discretion.
- Any elective surgery.
- Custodial Care.
- Pre-existing conditions not disclosed on the application.





The ~~WW~~ Major Medical Plan

Petersen International Underwriters

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To be eligible for this coverage, you must reside outside the United States for more than 5 months per year. Benefits may be assignable. Benefits are subject to all terms, limitations and conditions outlined in your certificate. Please read your certificate carefully once you receive it.

Proposed Insured: First _____ Middle _____ Last _____

Gender: Male Female Height _____ Weight _____ Date of Birth ____/____/____

USA Address: Number & Street _____

City _____ State _____ Zip Code _____

Contact Information: E-mail Address _____

Telephone (____) _____ - _____ Fax (____) _____ - _____

Citizenship: _____ Occupation: _____

Primary Care Physician: Name _____ Address _____

Date & Reason Last Seen: Date _____ Reason Seen _____ Results _____

Time Outside USA: _____ Months — Must be at least 5 months over the next 12 month period.

Effective Date : _____ Deductible: \$500 \$1,000 \$2,500 \$5,000

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Optional Coverages: War Coverage

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Medical History

Questions 1-5 must be answered to receive consideration for coverage. For any questions that you answer "YES," please provide details of the medical condition including treatment, dates, name address and phone number of attending physician, diagnosis, prognosis, and present course of treatment in the provided area below and if additional space is required please attach a separate sheet and submit it with the application. Please attach these responses to this application. The Underwriters may request additional medical information.

1. During the past 5 years, have you been diagnosed with any medical condition, received treatment (including medications or consultations), or been hospitalized for any medical, mental or nervous conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you currently disabled or unable to perform normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been declined or accepted on a modified term basis for life, disability or medical insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever received treatment or joined an organization for alcoholism or drug dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), Lymphadenopathy Syndrome, or any Immune System Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details: _____

Medical History - Continued

Applicant Name: _____

Date of Birth: _____

For any questions that you answer "YES," please provide details of the medical condition including treatment, dates, name address and phone number of attending physician, diagnosis, prognosis, and present course of treatment in the area provided below or in additional space is needed please use a separate sheet and submit the it along with the application. Please attach these responses to this application. The Underwriters may request additional medical information.

Questions 1-16 have you **EVER** been treated for, or have been told that, or have reason to believe that, you have any diseases, conditions, medical problems, disorders, sicknesses, or problems relating to any of the following:

1. Heart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Blood Vessels or circulatory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Blood Pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes or glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Cancer, tumor, cyst, and/or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Stomach, bowel and/or intestines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Kidney, liver and/or gall bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Lung and/or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Eyes, ears, nose, and/or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Mental and/or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Bone, skeleton, muscles, joints and/or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Genitourinary system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Back pain, Slipped Disc, and/or herniated disc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you ever been treated for or had any indication of physical disorder, injury or abnormality, not disclosed elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you been advised or recommended to receive medical attention that has not been received?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have you ever undergone a surgical operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you suffered from fainting episode, blackout, headache, migraines, seizures, and/or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Do you have any reason to believe that a surgical operation will be necessary in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Any other medications taken in the past 12 months? If Yes, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Are you currently taking medication? If Yes, please provide reason taking and medication.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details: _____

DECLARATION - Read Carefully

I read and/or understand English. I have read the above statements. I declare that the above information is true and complete to the best of my knowledge and belief. Apart from the matters disclosed above, I am in good health and ordinarily enjoy good health. **In the event of fraud, misstatements, concealment, or failure to disclose information on this application, whether intentional or inadvertent, any insurance issued based upon this application may become void and no benefits will be payable.**

Name: _____ Signature: _____ Date: _____



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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.*