Brand Protection Insurance Application Form

Policy Owner (Company): ______________________________

Address of Policy Owner: ______________________________

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Type of Business: ______________________________

Personal Information

Name of Insured Person: ______________________________

Date of Birth: _____/_____/__________

Occupation Including Duties: ______________________________

Period of Insurance: ____________________

Insurability

Please answer the following questions about the insured to the best of your knowledge and provide details.

1. Does the Insured participate in winter sports, other than skating or curling? ❑ Yes ❑ No
2. Does the Insured participate in water or underwater sports? ❑ Yes ❑ No
3. Does the Insured participate in rock climbing or mountaineering? ❑ Yes ❑ No
4. Does the Insured participate in motor sports or motorcycling? ❑ Yes ❑ No
5. Does the Insured participate in any **OTHER** activities excluded by your club contract? ❑ Yes ❑ No

Dates & Details to all "YES" answers to questions #1-5 ______________________________

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Financial Insurability

Requested Benefit Amount: $ ______________________________

*** Please include a copy of the signed agreement with this application ***

Declaration **(The Applicant must read this before signing)**

You should be aware that the policy wording contains exclusions in coverage in respect of AIDS, HIV, suicide, alcohol and drugs. To the best of my knowledge and belief the information provided in connection with this application, whether in my own hand or not, is true and I have not withheld any material fact. I understand that non-disclosure or misrepresentation of a material fact will entitle underwriters to void this insurance. (A material fact is one likely to influence acceptance or assessment of this application by underwriters.)

Policy Owner's Name: ____________________ Signature ____________________ Date ____________________

Authorization to Release Personal Information

In Compliance with HIPAA & Financial 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, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/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, 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. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. 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.*

Please Email, Fax or Mail This Form To:

Petersen
International Underwriters
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800.345.8816 toll-free • 661-254-0604 fax
www.piu.org • piu@piu.org