Disability Insurance Short Form Application

Petersen International Underwriters

Lloyd's Coverholder

23929 Valencia Blvd., Second Floor • Valencia, CA 91355-2186 • Tel (800) 345-8816 • Fax (661) 254-0604

Name: _____ Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ____

Address: _____

Occupation: _____ Specialty (if applicable): _____ Employer: _____

Email: _____ Telephone: (_____) _____ -_____

Bill To: ❑ Email ❑ Applicant's Address ❑ Employer - Attention: _____

❑ Other: _____

1. a. What were your earnings from you profession last year: (Gross income less business expenses, but before taxes) US$ _____

   b. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (circle items) US$ _____

   c. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? Is this included in 1a? Yes No US$ _____

2. Are you presently working full-time? ❑ Yes ❑ No

3. Is foreign travel or residence contemplated? ❑ Yes ❑ No
   If yes, where? _____

4. Have you consulted or been treated by a licensed physician, psychotherapist, psychologist, or other health care provider from inception date of your current expiring coverage? ❑ Yes ❑ No
   If yes, whom did you see? _____
   Address and phone number of Doctor seen: _____
   _____
   _____
   For what were you treated by this physician or health care provider?
   _____
   Date: _____ Results from this consultation or treatment?
   _____
   If more than one physician was seen, please explain on reverse side.

5. Have you received treatment or been advised to seek treatment for drug or alcohol abuse? ❑ Yes ❑ No

6. Have you filed a claim for disability benefits in the past 5 years? ❑ Yes ❑ No
   If yes, what was the nature of the accident or sickness? _____
   _____
   Date disability occurred: _____
   Time lost from work: _____

7. Has any application submitted by you within the last year for accident, sickness, hospitalization, major medical or life insurance been declined, postponed or increased in rate? ❑ Yes ❑ No
   (If yes, please provide details.) _____

8. Are you currently taking any medication? (If yes, please provide details of medications taken.) ❑ Yes ❑ No
   _____

9. To the best of your knowledge, are you now in good health and free from mental or physical impairment, abnormality, injury or disease? ❑ Yes ❑ No

10. Are you applying for, reinstating or have in force any disability insurance (including individual, group STD, group LTD, salary continuation benefits, mortgage and credit plans) other than this application? If yes, please list below. ❑ Yes ❑ No

Insurer	Approximate Date of Issue	Coverage Type	Monthly Benefit

IT IS UNDERSTOOD AND AGREED:

1. That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true;
2. That all answers on such questions, together with this agreement and any prior underwriting information, shall form the basis of the issuance of any coverage hereunder;
3. That in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable;
4. That except as amended by the answers to the above questions, any answer shown on any prior application for this coverage signed and dated by me are expressly reaffirmed.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, or other organization, institution or person, that has any record or knowledge of me or my health, to give to the certain underwriters at Lloyd's of London or its legal representative any such information.

AUTHORIZATION

Signature of Insured _____ Signature of Applicant-Purchaser if not Insured _____ 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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