PETERSEN® INTERNATIONAL UNDERWRITERS

ATHLETE APPLICATION

23929 Valencia Boulevard Second Floor, Valencia, CA 91355 | (800) 345-8816 | Fax (661) 254-0604 | piu@piu.org

Proposed Insured: First _____ Middle _____ Last _____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____

Gender: ❑ Male ❑ Female

Address: Number & Street _____

City _____ State _____ Zip Code _____

Sport: _____ Team Name: _____ Position: _____

Cell Phone *(optional)*: _____ Email *(optional)*: _____

Earned Income: *(Last Year)* _____ *After Expenses, Before Taxes* Endorsement Income: _____

Wherever "YES" answer(s) require full details including all applicable date(s), please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

1. Do you have any other disability insurance with anyone other than Petersen International Underwriters? ❑ 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: _____

Wherever "YES" answer(s) require full details including all applicable date(s), please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

8. Do you currently have an injury, illness, or any discomfort? ❑ Yes ❑ No

   If "Yes" please provide dates & 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 dates & details: _____

   _____

   _____

10. Have you missed any playing time during the last 24 months? ❑ Yes ❑ No

    If "Yes" please provide dates & details: _____

    _____

    _____

11. Within the last 24 months have you taken any pain-reducing or anti-inflammatory medication? ❑ Yes ❑ No

    If "Yes" please provide dates & 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 dates & 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? ❑ Yes ❑ No

    If "Yes" please provide dates & details: _____

    _____

    _____

14. Do you have any hardware (such as pin(s), screw(s), rod(s), plates, etc.) remaining? ❑ Yes ❑ No

    If "Yes" please provide dates & details: _____

    _____

    _____

Wherever "YES" answer(s) require full details including all applicable date(s), please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

15. Have you ever lost consciousness, been knocked out, or fainted? ❑ Yes ❑ No

If "Yes" please provide dates & 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 dates & details: _____

17. Have you had an injury, sickness, experienced symptoms or discomfort for which you have NOT sought medical advice, diagnosis, or treatment? ❑ Yes ❑ No

If "Yes" please provide dates & details: _____

18. Have you ever undergone hospitalization/treatment exceeding 14 days or surgery as a result of sickness or disease or a non-injury condition? ❑ Yes ❑ No

If "Yes" please provide dates & details: _____

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 dates & 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 dates & details: _____

Wherever "YES" answer(s) require full details including all applicable date(s), please indicate in the space provided. If there is not sufficient space, please attach your answers on a separate sheet.

21. Have you ever injured, sprained, strained, dislocated, torn, had tendonitis, discomfort, pain, or received a diagnosis, treatment 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 _____

Wherever "YES" answer(s) require full details including all applicable date(s), 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, received a diagnosis, been treated for or been prescribed treatment for any of the following conditions or body parts?:

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 shown indications of, received a diagnosis, been treated for or been prescribed treatment, for any sickness not listed above, for longer than 14 days?: ❑ Yes ❑ No

If "Yes" please provide details: _____

_____

24. Has a parent or sibling ever had diabetes, heart disease, cancer, or an inherited disorder? ❑ Yes ❑ No

If "Yes" please provide details: _____

_____

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 this application shall form the basis of the issuance of any coverage hereunder, 3) 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. 4) The underwriter has the right to require medical exams and tests to determine insurability. 5) I have read or had read to me and understand each of the questions and statements on this entire application. 6) No one has prevented me from spending as much time as I felt was necessary to understand this application.

Proposed Insured_____ Signature _____ Date_____

Please Print

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.

Proposed Insured Name	Date of Birth
Legal Representative*	Relationship
Email	

**If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.*

Signature of Proposed Insured _____ Date _____

Signature of Legal Representative (if other than Proposed Insured) _____ Date _____

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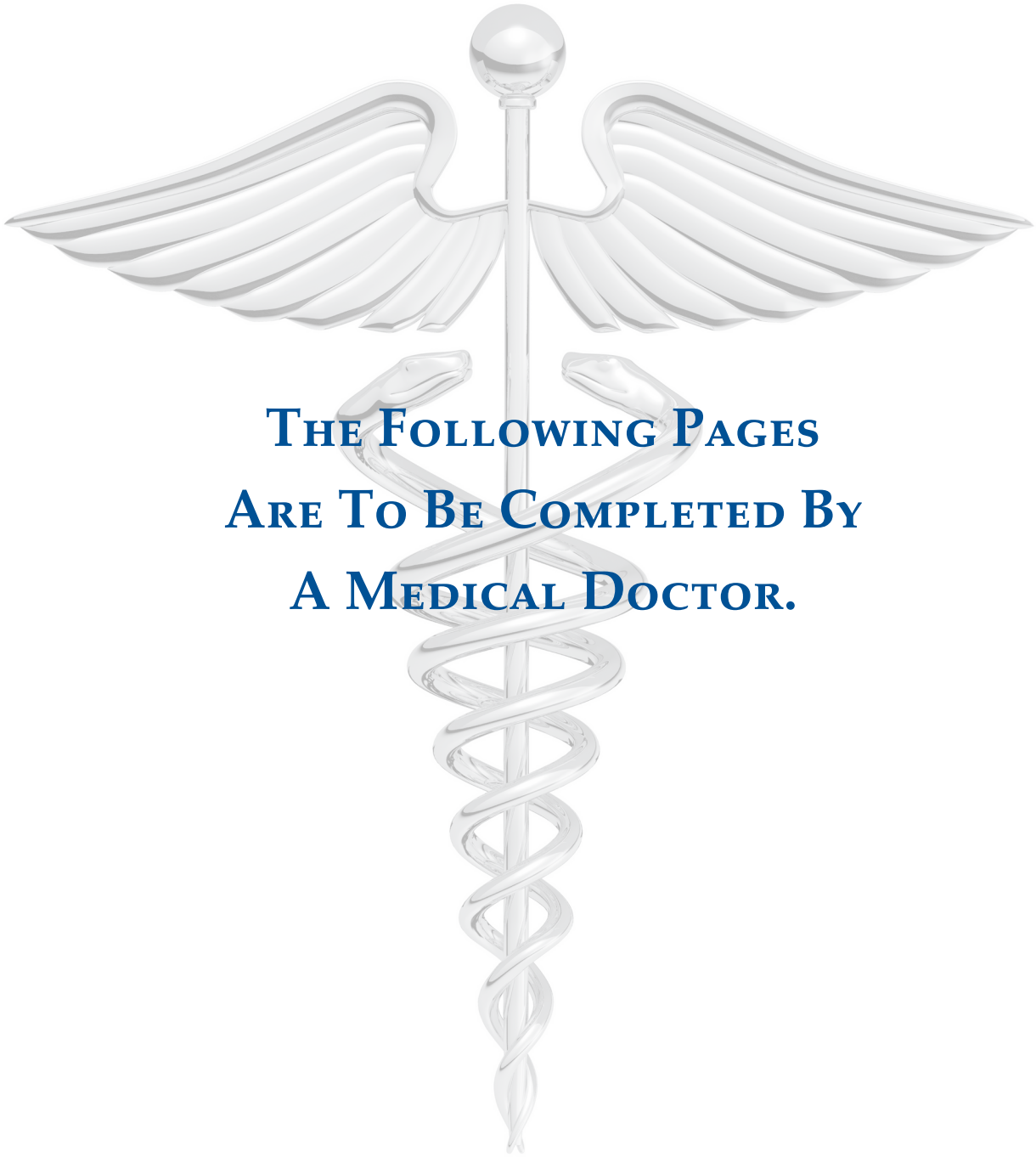

The Following Pages Are To Be Completed By A Medical Doctor.

PETERSEN® INTERNATIONAL UNDERWRITERS

MEDICAL DOCTOR REPORT

PROFESSIONAL ATHLETES

23929 Valencia Boulevard Second Floor, Valencia, CA 91355 | (800) 345-8816 | Fax (661) 254-0604 | piu@piu.org

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 experienced symptoms, pain or discomfort, had an injury, received a diagnosis, been prescribed or received treatment of any kind to any of the following? Doctor to query Proposed Inured. If answered "Yes" to any of the questions, please give details including dates (day/month/year).

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	_____

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)	❑	❑	_____
b.	Neck Or Cervical Spine?	❑	❑	_____
c.	Right Shoulder?	❑	❑	_____
d.	Left Shoulder?	❑	❑	_____
e.	Chest (Including Ribs)?	❑	❑	_____
f.	Upper Back (Thoracic Spine)?	❑	❑	_____
g.	Lower Back (Lumbar Spine Including Coccyx And Tail Bone)?	❑	❑	_____
h.	Pelvis/Hips (Including Groin - Specify Side)?	❑	❑	_____
i.	Abdomen (Including Stomach)?	❑	❑	_____
j.	Right Arm (Including Elbow)?	❑	❑	_____
k.	Left Arm (Including Elbow)?	❑	❑	_____
l.	Right Hand (Including Wrist & Digits)?	❑	❑	_____
m.	Left Hand (Including Wrist & Digits)?	❑	❑	_____
n.	Right Thigh (Including Hamstring)?	❑	❑	_____
o.	Left Thigh (Including Hamstring)?	❑	❑	_____
p.	Right Knee?	❑	❑	_____
q.	Left Knee?	❑	❑	_____
r.	Right Lower Leg (Including Ankle And Achilles Tendon)?	❑	❑	_____
s.	Left Lower Leg (Including Ankle And Achilles Tendon)?	❑	❑	_____
t.	Right Foot?	❑	❑	_____
u.	Left Foot?	❑	❑	_____

Proposed Insured: _____

If there is not sufficient space, please attach your answers on a separate sheet.

4. Please check the appropriate boxes:

		Normal	Abnormal	
a.	Head	❑	❑	_____
b.	Eyes, Ears, Nose & Throat	❑	❑	_____
c.	Skin	❑	❑	_____
d.	Lungs	❑	❑	_____
e.	Heart	❑	❑	_____
f.	Abdomen	❑	❑	_____
g.	Blood Pressure	❑	❑	_____
h.	Pulse	❑	❑	_____

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 _____