

Petersen International Underwriters

PART I. Producer #:_____

	pplicant's Name: First///		Heig	Height: Weight: _		Sex: □Male □Female		
	Address:							
	E-mail·							
Emp					-	_/		
• •								
Emproyer o riddress.		City State Zip Code						
Occupation:								
•		Length of Service:						
F	Policy Owner:	Loss Payee:						
10110) 0 1111011		(If other than I	an Insured)					
Owner Address:								
		City	State _		Zip Code			
Pre	emium Payor:	☐ Applicant	□ Employer	☐ Other:				
Pa	yment Mode:	☐ Multi-Year Prepay	☐ Annual	☐ Semi-Annual	☐ Quarterly	☐ Monthly (EFT/CC)		
	Bill To:	☐ Applicant's Address	☐ E-mail	☐ Employer - At	tention:			
		☐ Other:						
1.	Are you active	actively at work?						
	If "Yes	Yes" is answered for any of the following questions please provide full details in the space below. If there is not sufficient space, please attach your answers on a separate sheet.						
2.	Is foreign trav	vel or residence contemplated?						
3.	_	our occupation changed within the last 2 years?						
4.	Do you ever e	you ever engage in hazardous sports or hobbies?						
5.	Are you a par	e you a party to any legal proceeding at this time?						
6.	Are you aware	e you aware of any fact that could change your occupation or financial stability?						
7.	Do you have o	ve or have you ever had a professional license for your occupation? \square Yes \square No						
8.		f the answer to Question 7 is "Yes" has that license ever been suspended, revoked, restricted or has here ever been any hearing, or is a hearing pending concerning that professional license?						
9.	Have you ever	ever been convicted of any felony or misdemeanor or do you have any charges pending?						
10.	Have you or a	any business of which you had any ownership in filed for bankruptcy in the last 5 years?						
11.	Have you had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated? ☐ Yes ☐ No							
12.	Have you ever had disability, life, health, or accident insurance declined, postponed, cancelled, rated, or modified, or reinstatement of such refused? ☐ Yes ☐ No					ed, □ Yes □ No		
	Details:	Details:						

PLEASE INITIAL THE FOLLOWING

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application.



PETERSEN INTERNATIONAL UNDERWRITERS

PART I. FINANCIAL INFORMATION Current YTD Last Year Two Years Ago 20 20 20 What was your gross earned income less business US\$_____US\$_____ expenses, but before taxes from your profession? What was "other income" from dividends, interest, US\$ US\$ US\$____ rents, royalties, estates and trusts, etc.? (Circle items.) a) What was contributed to IRA, HR10, qualified pension US\$_____US\$_____US\$____ or profit-sharing plan? b) Is this included in #13? ☐ Yes ☐ No Please indicate the type of coverage and the amount of coverage that you are applying for. If a proposal was obtained, please provide the proposal number being applied for (lower left corner): 16. 17. ☐ Personal ☐ Overhead Expense ☐ Key Person ☐ Loan Indemnification ☐ Buy/Sell Other Section I — Monthly Benefits (if applicable) 18. Monthly Benefit requested: US\$ Elimination Period requested: Days Benefit Period requested: Months **Section I - Optional Riders:** ☐ Residual □ COLA ☐ Partial (Key Person Only) ☐ Prime Flex (Loan Indemnification Only) ☐ Salary Replacement Rider (Overhead Expense Only) Section II — Lump Sum Benefit (if applicable) Principal Sum requested: US\$ Elimination Period requested: Months ADDITIONAL POLICY INFORMATION Does your employer provide disability benefits or salary continuation benefits? ☐ Yes ☐ No Please list all disability insurance (including individual, group, mortgage, and credit plans) for which you are applying, have in force, or are reinstating. If none, please indicate "None". ☐ None Business Overhead Monthly Benefit Other Disability Insurer Issue Date | Personal DI Monthly Benefit | Buy/Sell Disability If "None" was answered for question #21, please proceed to question #23. ☐ Yes ☐ No Are you terminating any existing policies listed above in order to qualify for the coverage now being applied for? If "Yes" please indicate the coverage that is to be terminated. _

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Petersen International Underwriters

PART II.

(Use additional sheets if needed)

MEDICAL INFORMATION								
23.	Prima	Primary care physician:		a. Name & address:b. Date and reason last seen:c. Results of last visit:				
24.	4. Last healthcare provider seen:		b. D	a. Name & address:b. Date and reason last seen:c. Results of last visit:				
		•			_	s please provide full h your answers on a	details in the space below	v.
25.	Have	Ť				or disorder involving	-	
	a.	Eyes	☐ Yes ☐	l No	aa.	Gall bladder	-	☐ Yes ☐ No
	b.	Ears	☐ Yes ☐		ab.	Convulsions/Seizure	es	☐ Yes ☐ No
	c.	Nose	☐ Yes ☐		ac.	Concussions		☐ Yes ☐ No
	d.	Cyst	☐ Yes ☐		ad.	Blood vessels		☐ Yes ☐ No
	e.	Gout	☐ Yes ☐		ae.	Lymph nodes		☐ Yes ☐ No
	f.	Knees	☐ Yes ☐		af.	Intestinal tract		☐ Yes ☐ No
	g.	Back/spine/neck	☐ Yes ☐		ag.	Urinary system		☐ Yes ☐ No
	h.	Skin	☐ Yes ☐	l No	ah.	Arthritis/joints /rhe	umatism	☐ Yes ☐ No
	i.	Liver	☐ Yes ☐	l No	ai.	Nervous system		☐ Yes ☐ No
	j.	Heart	☐ Yes ☐	l No	aj.	Growth/tumor		☐ Yes ☐ No
	k.	Blood	☐ Yes ☐	l No	ak.	Unconsciousness		☐ Yes ☐ No
	1.	Bones	☐ Yes ☐	No	al.	Circulatory system		☐ Yes ☐ No
	m.	Throat	☐ Yes ☐		am.	Fainting/dizziness		☐ Yes ☐ No
	n.	Hernia	☐ Yes ☐		an.	Paralysis/weakness		☐ Yes ☐ No
	0.	Cancer	☐ Yes ☐		ao.	High blood pressure		☐ Yes ☐ No
	p.	Bladder	☐ Yes ☐		ap.	Disorder of the brain		☐ Yes ☐ No
		Muscles	☐ Yes ☐		_	Mental/Emotional/F		☐ Yes ☐ No
	q. r.	Kidneys	☐ Yes ☐		aq. ar.	Lungs	Sycillatric	☐ Yes ☐ No
		Glands	☐ Yes ☐			Asthma		☐ Yes ☐ No
	S.		☐ Yes ☐		as.			☐ Yes ☐ No
	t.	Thyroid			at.	Allergies		
	u.	Pancreas	☐ Yes ☐		au.	Tuberculosis		☐ Yes ☐ No
	v.	Diabetes	☐ Yes ☐		av.	Respiratory system		☐ Yes ☐ No
	W.	Chest pain	☐ Yes ☐		aw.	Reproductive system		☐ Yes ☐ No
	х.	Headaches	☐ Yes ☐		ax.	Digestive system/sto		☐ Yes ☐ No
	y.	HIV/AIDS	☐ Yes ☐		ay.	Are you now pregna		☐ Yes ☐ No
	z.	Sleep apnea	☐ Yes ☐	l No	az.	Any condition not i	mentioned previously?	☐ Yes ☐ No
Que	estion #	Details of Conditions/Treatm		ment Date & Duration Details an		nd Degree of Recovery Doctors & Hospitals wit		h Addresses

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I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application.



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PART II.

MEDICAL INFORMATION CONTINUED

				g questions please provide full lease attach your answers on a	*	low.	
26.	Have you used tobacco at any time within the last three years?						
27.	Has your weight increased or decreased more than 10 pounds within the last year?						
28.	Are you now taking/using prescription medication and/or nonprescription medication?						
9.	In the last 60 days, have you taken any medicines which are not listed in #28?						
0.	Within the last 5 years have you had or been advised to have a surgical operation or hospitalization?						
1.							
32.							
3.							
84.							
55.	Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other drugs?						
66.	6. Within the last 5 years have you received medical treatment, attended a program or been counseled for alcohol or drug abuse or been advised by a member of the medical profession to reduce the use of alcohol?						
Qu	nestion # Details of Conditions/Treatment Date & Duration Details and Degree of Recovery Doctors & Hospitals					with Addresses	
	To the	al sheets if needed) best of your knowledge and beli ed in this application? ☐ Yes ☐		d health and free from any ment use provide details:	al or physical impairme	nt, except as	
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.							

- 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, and
- the insurance hereunder applied for shall take effect on the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.
- I have read or had read to me and understand each of the questions and statements on this entire application.
- No one has prevented me from spending as much time as I felt was necessary to understand this application. Signature of Policy Owner - (if not Applicant) Signature of Applicant

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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