PETERSEN®
INTERNATIONAL UNDERWRITERS

Disability Short Form Application

Insured: _____ Date of Birth: _____ Gender: _____

Employer's Name: _____

Occupation/Specialty: _____ Loss Payee: _____

Policy Owner Name: _____

Policy Owner Address: _____

_____

Billing Address: _____

_____

Email Address: _____ Phone Number: _____

Bill to *(select one)*: ❑ Billing Address or ❑ Email Address

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1. What were your earnings from your profession last year: US$ _____
   (Gross income less business expenses, but before taxes including your net K-1 earnings/loss from your occupation)
2. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (circle items) US$ _____
3. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? US$ _____
   Is this included in Question #1? ❑ Yes ❑ No

If "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.

4. Within the last policy term, have you received treatment or been advised to seek treatment for drug or alcohol abuse? ❑ Yes ❑ No
5. Within the last policy term, have you filed a claim for disability benefits? ❑ Yes ❑ No
6. Within the last policy term, has any application submitted by you for accident, sickness, hospitalization, major medical or life insurance been declined, postponed or increased in rate? ❑ Yes ❑ No
7. Are you presently working less than 30 hours per week? ❑ Yes ❑ No
8. Is foreign travel or residence contemplated? ❑ Yes ❑ No
9. Do you ever engage in hazardous sports, hobbies or activities? ❑ Yes ❑ No
10. Within the last policy term, have you increased or decreased any of your disability insurance benefits? ❑ Yes ❑ No

Question #	Please provide detailed information for each question answered "Yes"

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. _____

11. Primary care physician:
    a. Name: _____
    b. Address: _____
    c. Date and reason last seen: _____
    d. Results of last visit: _____

12. 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"please provide additional details in the following table below.

Healthcare Provider Name	Healthcare Provider Address & Phone Number	Reason(s) Seen	Date	Consultation or Treatment Results

13. Height: _____ Weight: _____

14. Are you currently taking medicine or taken any medicine in the last 60 days? ❑ Yes ❑ No
    If "Yes"please provide additional details in the following table below.

Name of Medication	Reason Taken	Date Last Taken

15. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application? ❑ Yes ❑ No - If No, 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 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.

_____ _____
Signature of Insured Date

Policy Owner *(if not Insured)*

_____ _____
Name Title

_____ _____
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.

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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23929 Valencia Boulevard • Second Floor • Valencia, CA 91355
800.345.8816 toll-free • 661-254-0604 fax
www.piu.org • piu@piu.org