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

Insured: ____________ """""""""Date of Birth:"""""""""""""""""""""""""""""""""I ender: ______

Employer's Name:" ____________

Occupation/Specialty:" ____________ """"""""Loss Payee:" ____________

Policy Owner Name:" ____________

Policy Owner Address: " ____________

Billing Address: ____________ Attn: ____________

Email Address: ____________ Phone Number: ____________

1. a. What were your earnings from your 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 healthcare provider? ____________
   Date: ____________ Results from this consultation or treatment? ____________
   If more than one physician was seen, please explain on reverse side.

5. What is your current: Height: ____________ Weight: ____________

6. Have you received treatment or been advised to seek treatment for drug or alcohol abuse? ❑ YES ❑ NO

7. 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: ____________

8. 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) ____________

9. Are you currently taking medication? (If yes, please provide details on medication taken. ❑ YES ❑ NO
   ____

10. 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

11. 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 questions 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

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