PETERSEN® INTERNATIONAL UNDERWRITERS

Professional Athlete
Short Form 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 Daytime Phone Number: _____

Address: Number & Street _____

City _____ State _____ Zip Code _____

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

Sport: _____ League: _____

Team: _____ Position: _____

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

COVERAGE APPLYING FOR	
☐ PTD (Permanent Total Disability)	☐ TTD (Temporary Total Disability)
Benefit Requested: $	Monthly Benefit Requested: $_____ Benefit Period Requested: $_____ Elimination Period Requested: $_____ Days

QUESTIONNAIRE

1. Are you currently free of injury and illness and playing for your sport? ☐ Yes ☐ No

2. Have you during the last 24 months missed any playing time due to injury or illness? If "Yes", enter dates, reason(s) and total number of games missed. ☐ Yes ☐ No
_____
_____

3. Have you any reason to think that you may need to undergo a surgical operation and/or medical treatment in the future? Give details _____ ☐ Yes ☐ No

4. Do you engage in any other sport(s) and/or activities other than the sport which is your primary occupation? Please give dates and for what reasons. _____ ☐ Yes ☐ No
_____

5. Are you taking or have you taken any medication in the past 2 years? Please give dates and for what reasons. _____ ☐ Yes ☐ No
_____

6. Have you any physical defect or infirmity? Give details. _____ ☐ Yes ☐ No
_____

7. Is your sight in any way impaired; have you ever had symptoms, received a diagnosis, been prescribed or received treatment in respect of the eyes? Give details. _____ ☐ Yes ☐ No
_____

8. Is your hearing impaired; have you ever had any discharge from the ears? Give details. _____ ☐ Yes ☐ No
_____
_____

9. Have you ever had symptoms, received a diagnosis, been prescribed or received treatment in respect of Appendicitis, Asthma, Blood Pressure Abnormalities, Blood-spitting, Diabetes, Dyspepsia, Fits, Gout, Hernia, Paralysis, Piles, Rheumatism, or any Rheumatic infection, Skin Infections, Varicose Veins, or any Diseases or Disorders of the Chest or Respiratory System, Heart, Stomach, Bladder or Nervous System? Give dates and state if operation performed. _____ ☐ Yes ☐ No

10. Do you have any hardware remaining (such as pins, screws, rods, plates, etc.)? Details _____ ☐ Yes ☐ No

11. In the past 5 years have you had symptoms, received a diagnosis, been prescribed or received treatment from any other illness or accident? If so, give details and dates. _____ ☐ Yes ☐ No

12. Have you consulted a doctor during the past 2 years? Please give dates, for what reasons, and what were the results. _____ ☐ Yes ☐ No

13. 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

14. Have you ever made any claim for accident or illness? If yes, please state each case as to nature of claim, date, amount and name of company or underwriter. _____ ☐ Yes ☐ No

15. Have you ever been declined, or accepted on special terms, for life insurance or insurance against accident or illness? _____ ☐ Yes ☐ No

16. Has any company or underwriter ever cancelled or declined to renew your policy? Give details. _____ ☐ Yes ☐ No

17. Do you engage in any sport(s) as a professional other than the sport, which is your prime occupation? If so give details. _____ ☐ Yes ☐ No

18. Are you now and have you been perfectly well and in sound health for a year preceding this application? ☐ Yes ☐ No

AUTHORIZATION

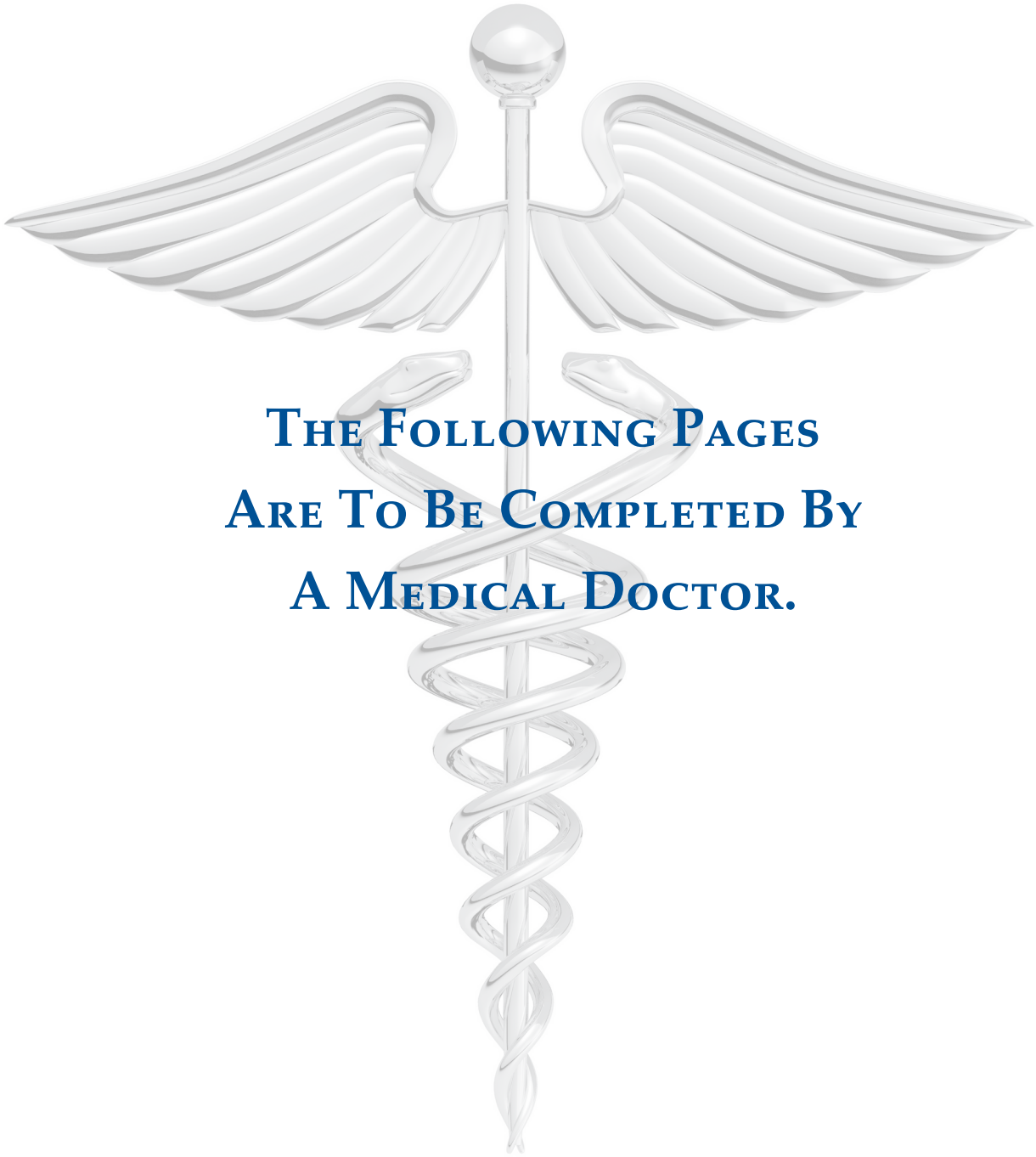
I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, THAT HAS RECORDS OR KNOWLEDGE OF ME OR MY HEALTH, TO RELEASE SUCH DOCUMENTATION TO PETERSEN INTERNATIONAL UNDERWRITERS.

DECLARATION

I hereby warrant that all the answers and statements herein contained are full, complete and true and have been correctly recorded and I have not withheld any information which is likely to influence the decision of the underwriter and that 1 am willing to accept a policy, subject to the terms and conditions of such policy, to be issued on the basis of and in consideration of the proposal. The insurance applied for will not take effect unless the health of the Proposed Insured remains as stated in the Application on the inception date of the policy. Underwriters do not bind themselves to accept this application for insurance, and reserve the right to decline and/or impose specific exclusions as a result of information disclosed herein.

Proposed Insured _____ Date _____

Signature of Applicant _____



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

MEDICAL DOCTOR REPORT

PROFESSIONAL ATHLETES

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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).

Head? (Including Concussion Or Unconsciousness)	☐ Yes ☐ No	_____
Neck Or Cervical Spine?	☐ Yes ☐ No	_____
Right Shoulder?	☐ Yes ☐ No	_____
Left Shoulder?	☐ Yes ☐ No	_____
Chest (Including Ribs)?	☐ Yes ☐ No	_____
Upper Back (Thoracic Spine)?	☐ Yes ☐ No	_____
Lower Back (Lumbar Spine Including Coccyx And Tail Bone)?	☐ Yes ☐ No	_____
Pelvis/Hips (Including Groin - Specify Side)?	☐ Yes ☐ No	_____
Abdomen (Including Stomach)?	☐ Yes ☐ No	_____
Right Arm (Including Elbow)?	☐ Yes ☐ No	_____
Left Arm (Including Elbow)?	☐ Yes ☐ No	_____
Right Hand (Including Wrist & Digits)?	☐ Yes ☐ No	_____
Left Hand (Including Wrist & Digits)?	☐ Yes ☐ No	_____
Right Thigh (Including Hamstring)?	☐ Yes ☐ No	_____
Left Thigh (Including Hamstring)?	☐ Yes ☐ No	_____
Right Knee?	☐ Yes ☐ No	_____
Left Knee?	☐ Yes ☐ No	_____
Right Lower Leg (Including Ankle And Achilles Tendon)?	☐ Yes ☐ No	_____
Left Lower Leg (Including Ankle And Achilles Tendon)?	☐ Yes ☐ No	_____
Right Foot?	☐ Yes ☐ No	_____
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	
Head	☐	☐	_____
Eyes, Ears, Nose & Throat	☐	☐	_____
Skin	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Abdomen	☐	☐	_____
Blood Pressure	☐	☐	_____
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 _____

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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