

# KEY PERSON FAILURE TO SURVIVE

“Providing Unique  
Solutions For The  
Corporate World”

FOR

- Key Employees
- Most Third Party Contracts



**PETERSEN**  
International Underwriters

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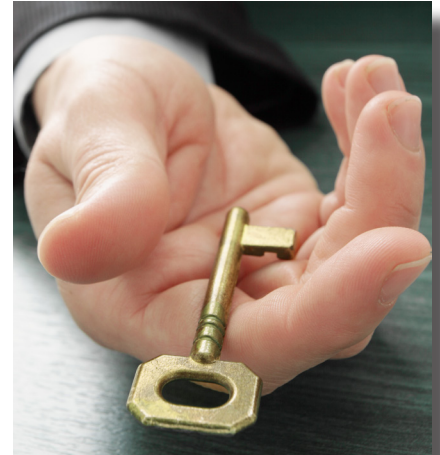
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# KEY PERSON FAILURE TO SURVIVE

## KEY PERSON FAILURE TO SURVIVE

The underwriters will pay the amount shown in the schedule for the direct financial loss suffered by the assured resulting from non-performance of the insured contract due solely to the death or disappearance of the insured person during the period of insurance.

In the event that the insured contract is terminated, this insurance shall automatically and immediately come to an end simultaneously with the effective date of termination of the insured contract, without further notice.



### Policy & Underwriting Information

- The term of insurance up to 12 months
- Renewals are considered if continued coverage is needed
- No medical exams or medical records are required for application

### Coverage would be appropriate for clients when...

- Coverage is needed quickly
- Completing a medical exam would be an issue
- Proposed insured is temporarily out of the U.S.A.
- Coverage is needed for a short period of time
- Health issues are a concern
- Issue limits are a problem

This is not intended to be a complete outline of coverage. Actual wording may change without notice.  
Underwriters reserve the right to modify terms and benefits at time of underwriting.

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## Exclusions

1. Suicide, intentional self-injury or the voluntary disappearance of the insured person.
2. Active participation in terrorism or war.
3. Nuclear, biological or chemical exposure as a result of terrorism or war.
4. While committing or attempting to commit a felony.
5. Any emotional or psychiatric problems, including but not limited to neurotic disorders such as anxiety, phobias, depressions, dissociative disorders and obsessive compulsive disorders; psychotic disorders such as schizophrenia, paranoid psychosis and affective disorders; and personality disorders such as sociopathic personality.
6. Taking of illegal drugs, or addiction or misuse of prescription or non-prescription drugs.
7. Alcohol abuse or addiction, being under the influence of alcohol, as defined by the vehicle code of the state or province in which the offense has occurred.
8. Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any virus, complex or syndrome that is related to the foregoing or any sexually transmitted disease.
9. War, whether declared or not, between any of the following countries, namely, China, France, the United Kingdom, the Russian Federation and the United States of America.
10. War in Europe, whether declared or not, other than: i. civil war ii. any enforcement action by or on behalf of the United Nations, in which China, France, the United Kingdom, the Russian Federation and the United States of America or any armed forces thereof are engaged.
11. If the Insurer alleges that by reason of any exclusion a claim is not covered by this insurance then the burden of proving the contrary shall be upon the Insured.
12. Pre-Existing Conditions which are physical, mental or chemical conditions which arise from any Accident or Sickness which was: a) not disclosed on the application, and b) for which the Insured Person sought any medical advice or treatment within twenty four (24) months prior to the effective date of this Certificate or which caused symptoms for which an ordinarily prudent person would have sought medical advice within that twenty four (24) month period.

## Underwriting Guidelines

Notice must be given to the Insurer as soon as reasonably possible of anything which results or may result in a claim under this Insurance. The Insured must keep all records so that the amount of any claim can be determined. All such records must be available for inspection by the Insurer in the event of a claim.

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Underwriters reserve the right to modify terms and benefits at time of underwriting.

Producer #: \_\_\_\_\_

## KEY PERSON FAILURE TO SURVIVE APPLICATION FORM

Policy Owner/Beneficiary (Not the Insured): \_\_\_\_\_

Address of Policy Owner: \_\_\_\_\_

Type of Business: \_\_\_\_\_

### PROPOSED INSURED PERSON INSURABILITY

**This section must be completed by the proposed insured person.**

Name of Insured Person: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation Including Duties: \_\_\_\_\_

Period of Insurance: \_\_\_\_\_

**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.**

- |                                                                                                                                                                                                     |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Do you have any physical health problems or suffer from, been diagnosed with, received treatment for, or been prescribed treatment for any condition related to, or from a sickness of any kind? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been diagnosed with a heart condition, high blood pressure, diabetes or cancer?                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you at any time been physically or mentally unable to work during the last 12 months?                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever been declined or accepted on special terms for life, accident or illness insurance?                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you intend to engage in hazardous sports or any activities that expose you to personal injury?                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Are you planning to undertake any foreign travel during the next 12 months?                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Do you hold a valid pilot license?                                                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have you ever had any criminal convictions?                                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Details to the answers above: \_\_\_\_\_

### FINANCIAL INSURABILITY

Requested Benefit Amount: \$ \_\_\_\_\_

Please indicate the total financial loss in the event of death of the Key Person. If any other financial documentation is available, please send along with this application.

- |                                                        |          |
|--------------------------------------------------------|----------|
| 1. Loss of revenue due to death of Key Person:         | \$ _____ |
| 2. Costs which will be incurred to find a replacement: | \$ _____ |
| 3. Cost of temporary replacement staff:                | \$ _____ |
| 4. Valuation of ownership:                             | \$ _____ |
| 5. Loss of future accounts:                            | \$ _____ |
| 6. Total loss from death:                              | \$ _____ |

**Declaration (The Applicant must read this before signing)** I am aware that the policy wording contains exclusions in coverage in respect of AIDS, HIV, suicide, alcohol and drugs. To the best of my knowledge and belief the information provided in connection with this application, whether in my own hand or not, is true and I have not withheld any material fact. I understand that non-disclosure or misrepresentation of a material fact will entitle underwriters to void this insurance. (A material fact is one likely to influence acceptance or assessment of this application by underwriters.

Insured's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_