Producer #:_____

Accident Only Major Medical Plan

This is a temporary accident only major medical insurance plan intended for indemnification of eligible expenses from injuries. Benefits may be assignable once validated. Until then, benefits are paid directly to you to **reimburse** you for necessary medical expenses which have been paid by you, subject to terms and conditions as outlined in the certificate. **This is not a Patient Protection and Affordable Care Act (PPACA) compliant plan.**

Name (Last, First)	Date of Birth	Gender	Period of Coverage
	/ /	M / F	/ / thru / /
	/ /	M / F	
	/ /	M / F	
	/ /	M / F	
	/ /	M / F	

USA Address: Number & Street _____

City _____ State_____ Zip Code _____

Contact Information: Email _____ Telephone (_____)_____-_____

Do you need coverage outside the USA? *If "Yes" Please specify locations* ❑ Yes ❑ No _____

_____

Benefits: Deductible _____ Maximum Benefit _____

Optional Coverage: ❑ Hazardous Sports

Payment Information

1. Check - Payable to Petersen International Underwriters
2. Credit Card: ❑ Monthly Payment ❑ In Full Payment

Premium Amount: $_____

Credit Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: __ __ / __ __

Security Code: _____

DECLARATION

I declare that the above statements are true and complete, and that, apart from the matters declared above, I am in good health and ordinarily enjoy good health. 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 any such information to Petersen International Underwriters or its representatives. I agree that , if accepted, this application shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission.

I understand that pre-existing conditions are not covered.

I also understand that since this is an accident only policy it is exempt from the Patient Protection and Affordable Care Act (PPACA).

Proposed Insured_____ Signature _____ Date_____

Please Print (Parent/Guardian signature if applicant is under age 18)