The Bridge Plan Application Form

Producer Number:_____

To be eligible for the Bridge Plan coverage, you must attest to the following statements:

- ☐ I attest that I am not eligible for Medicare or Affordable Care Act (PPACA) compliant insurance.
- ☐ I attest that I have tried, but was unable to obtain short-term medical insurance. Reason _____

Applicant's Name: First _____ Middle _____ Last_____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Residence Address: _____

City _____ State _____ Zip Code _____

E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____

Requested Start Date: _____ Date you expect to be eligible for Medicare: _____

Plan Type: ☐ **Platinum** *($1,000,000 Max. & $1,000 Deductible)* ☐ **Gold** *($500,000 Max. & $2,500 Deductible)*
☐ **Silver** *($250,000 Max. & $5,000 Deductible)* ☐ **Bronze** *($100,000 Max. & $10,000 Deductible)*

Coverage Type: ☐ Bridge Part A & B ☐ Bridge Part A Only ☐ Bridge Part B Only

Last healthcare provider seen:
a. Doctors Name & Address: _____
b. Date and reason last seen: _____
c. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided below or attach a separate page if needed

1. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ☐ Yes ☐ No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ☐ Yes ☐ No
3. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ☐ Yes ☐ No
4. Have you ever been evaluated or treated for any injury, condition or disorder involving the following? ☐ Yes ☐ No

a.	Eyes/Ears	☐ Yes ☐ No	o.	Back/spine/neck	☐ Yes ☐ No
b.	Gout	☐ Yes ☐ No	p.	Throat/Thyroid/Glands	☐ Yes ☐ No
c.	Skin	☐ Yes ☐ No	q.	Bones/Bone Density	☐ Yes ☐ No
d.	Hernia	☐ Yes ☐ No	r.	Arthritis/Joints (Hips Knees, Shoulders)	☐ Yes ☐ No
e.	Diabetes	☐ Yes ☐ No	s.	Fainting/Dizziness/Unconsciousness	☐ Yes ☐ No
f.	HIV/AIDS	☐ Yes ☐ No	t.	Fatigue/Tiredness/Paralysis/Weakness	☐ Yes ☐ No
g.	Sleep apnea	☐ Yes ☐ No	u.	Nervous System/Alzheimer's/Dementia	☐ Yes ☐ No
h.	Gallbladder	☐ Yes ☐ No	v.	Mental/Emotional/Psychiatric	☐ Yes ☐ No
i.	Concussions	☐ Yes ☐ No	w.	Respiratory System/Asthma	☐ Yes ☐ No
j.	Chronic Pain	☐ Yes ☐ No	x.	Circulatory system	☐ Yes ☐ No
k.	Lymph nodes	☐ Yes ☐ No	y.	Reproductive system	☐ Yes ☐ No
l.	Cancer/Growth	☐ Yes ☐ No	z.	Gastrointestinal System	☐ Yes ☐ No
m.	High blood pressure	☐ Yes ☐ No	aa.	Urinary system/Prostate	☐ Yes ☐ No
n.	Heart/Chest Pain/Stroke	☐ Yes ☐ No	ab.	Any other condition not listed above	☐ Yes ☐ No

5. Has your weight changed in the past year? ☐ Yes ☐ No
6. Have you ever undergone a surgical operation? ☐ Yes ☐ No
7. Have you taken any medicines in the past 12 months? ☐ Yes ☐ No
8. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed? ☐ Yes ☐ No
9. Other than the medical conditions noted on this application, I am in good health. ☐ Yes ☐ No
10. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ☐ Yes ☐ No

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

DECLARATION

I declare that the above statements are true and complete. I am in good health and ordinarily enjoy good health. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that this is a temporary insurance policy designed to cover the insured person for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product. I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured_____ Signature _____ Date_____
Please Print

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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