Application For Disability Insurance

Petersen International Underwriters

PART I. **Producer #:**_____

Insured's Name: First _____ M.I. _____ Last _____ Designation:_____

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

Address: _____

City _____ State _____ Zip Code _____

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

Employer's Name: _____

Employer's Address: _____

City _____ State _____ Zip Code _____

Occupation: _____ Daily Duties: _____

Specialty: _____ Length of Service: _____

Owner's Name: _____ Loss Payee: _____

(If other than Insured) *(If other than Insured)*

Owner Address: _____

City _____ State _____ Zip Code _____

Payment Mode: ❑ Multi-Year Prepay ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly (EFT/CC)

Bill To: ❑ Insured's Address ❑ E-mail ❑ Owner's Address ❑ Employer - Attn: _____

(Please Select One) ❑ Other: _____

1. Are you actively at work? ❑ Yes ❑ No

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.

2. Is foreign travel or residence contemplated? ❑ Yes ❑ No
3. Has your occupation changed within the last 2 years? ❑ Yes ❑ No
4. Do you ever participate in hazardous sports or hobbies? ❑ Yes ❑ No
5. Do you engage in volunteer civil service or emergency responding? ❑ Yes ❑ No
6. Are you a party to any legal proceeding at this time? ❑ Yes ❑ No
7. Are you presently working less than 30 hours per week? ❑ Yes ❑ No
8. Are you aware of any fact that could change your occupation or financial stability? ❑ Yes ❑ No
9. Do you have or have you ever had a professional license for your occupation? ❑ Yes ❑ No
10. If the answer to Question 9 is "Yes" has that license ever been suspended, revoked, restricted or has there ever been any hearing, or is a hearing pending concerning that professional license? ❑ Yes ❑ No
11. Have you ever been convicted of any felony or misdemeanor or do you have any charges pending? ❑ Yes ❑ No
12. Have you or any business of which you had any ownership in filed for bankruptcy in the last 5 years? ❑ Yes ❑ No
13. Have you had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated? ❑ Yes ❑ No

Details: _____

_____

PLEASE INITIAL THE FOLLOWING - I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application. _____

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PART I.

	Current Year Projection	Last Year	Two Years Ago
14. What were your earnings from your occupation?			
a. Gross wages (as an employee)?	US$ _____	US$ _____	US$ _____
b. Net earnings from self employment (gross revenue less expenses)?	US$ _____	US$ _____	US$ _____
c. Non-passive Business Income (K-1, including guaranteed payments)?	US$ _____	US$ _____	US$ _____
15. What was contributed to qualified pensions, profit sharing, IRA or other retirement plans?	US$ _____	US$ _____	US$ _____

a. Is this included in Question #14a? ❑ Yes ❑ No

**If blank, it is understood to be zero.*

Please indicate the type of coverage and the amount of coverage that you are applying for.

16. If a proposal was obtained, please provide the proposal number being applied for (lower left corner): _____

17. ❑ Personal ❑ Overhead Expense ❑ Key Person ❑ Loan Indemnification ❑ Buy/Sell Other ❑ _____

18A. **Section I — Monthly Benefits (if applicable)**

Monthly Benefit requested: _____ US$
Elimination Period requested: _____ Days
Benefit Period requested: _____ Months

18B. **Section I - Optional Riders:**

❑ Residual
❑ COLA
❑ Partial (Key Person Only)
❑ Prime Flex (Loan Indemnification Only)
❑ Salary Replacement Rider Requested: _____ (Overhead Expense Only)

19. **Section II — Lump Sum Benefit (if applicable)**

Principal Sum requested: _____ US$
Elimination Period requested: _____ Months

20. Does your employer provide disability benefits or salary continuation benefits? ❑ Yes ❑ No

21. Please list all disability insurance (including individual and group) for which you are applying, have in force, or are reinstating. *If none, please indicate "None" and skip to Question #24.* ❑ None

Insurer	Issue Date	Personal DI Monthly Benefit	Business Overhead Monthly Benefit	Buy/Sell Disability	Other Disability

22. Do any of the above disability policies have any exclusions or ratings? ❑ Yes ❑ No
If "Yes" please advise _____

23. Are you terminating any existing policies listed above in order to qualify for the coverage now being applied for? ❑ Yes ❑ No
If "Yes" please indicate the coverage that is to be terminated. _____

24. Have you ever had disability, life, health, or accident insurance declined, postponed, cancelled, rated, or modified, or reinstatement of such refused? _____ ❑ Yes ❑ No

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25. Primary care physician:
    a. Name & address: _____
    b. Date and reason last seen: _____
    c. Results of last visit: _____

26. Healthcare provider(s) seen in the last 3 years: *(other than the primary care provider above. If blank, it is understood to be none seen.)*
    a. Name & address: _____
    b. Date and reason last seen: _____
    c. Results of last visit: _____

27. a. Name & address: _____
    b. Date and reason last seen: _____
    c. Results of last visit: _____

28. a. Name & address: _____
    b. Date and reason last seen: _____
    c. Results of last visit: _____

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.

29. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?

a.	Eyes	❑ Yes ❑ No	s.	Thyroid	❑ Yes ❑ No	ak.	Reproductive system	❑ Yes ❑ No
b.	Ears	❑ Yes ❑ No	t.	Pancreas	❑ Yes ❑ No	al.	Legs/Knees/Feet	❑ Yes ❑ No
c.	Nose	❑ Yes ❑ No	u.	Chest pain	❑ Yes ❑ No	am.	Shoulders/Arms/Hands	❑ Yes ❑ No
d.	Cyst	❑ Yes ❑ No	v.	Headaches	❑ Yes ❑ No	an.	Convulsions/Seizures	❑ Yes ❑ No
e.	Gout	❑ Yes ❑ No	w.	HIV/AIDS	❑ Yes ❑ No	ao.	Diabetes/Pre-Diabetes	❑ Yes ❑ No
f.	Skin	❑ Yes ❑ No	x.	Sleep apnea	❑ Yes ❑ No	ap.	Are you now pregnant?	❑ Yes ❑ No
g.	Liver	❑ Yes ❑ No	y.	Gall bladder	❑ Yes ❑ No	aq.	Urinary system/Bladder	❑ Yes ❑ No
h.	Heart	❑ Yes ❑ No	z.	Concussions	❑ Yes ❑ No	ar.	Blood Clotting/Bleeding	❑ Yes ❑ No
i.	Blood	❑ Yes ❑ No	aa.	Tuberculosis	❑ Yes ❑ No	as.	Lungs/Respiratory System	❑ Yes ❑ No
j.	Bones	❑ Yes ❑ No	ab.	Lymph nodes	❑ Yes ❑ No	at.	Arthritis/joints /rheumatism	❑ Yes ❑ No
k.	Glands	❑ Yes ❑ No	ac.	Growth/tumor	❑ Yes ❑ No	au.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
l.	Throat	❑ Yes ❑ No	ad.	Nervous system	❑ Yes ❑ No	av.	High Cholesterol/Triglycerides	❑ Yes ❑ No
m.	Hernia	❑ Yes ❑ No	ae.	Chronic Fatigue	❑ Yes ❑ No	aw.	Blood vessels/Circulatory System	❑ Yes ❑ No
n.	Cancer	❑ Yes ❑ No	af.	Back/spine/neck	❑ Yes ❑ No	ax.	Disorder of the brain/brain injury	❑ Yes ❑ No
o.	Asthma	❑ Yes ❑ No	ag.	Unconsciousness	❑ Yes ❑ No	ay.	Gastrointestinal tract/Stomach/Esophagus	❑ Yes ❑ No
p.	Muscles	❑ Yes ❑ No	ah.	Fainting/dizziness	❑ Yes ❑ No	**az.**	**Any condition not mentioned previously?**	❑ Yes ❑ No
q.	Kidneys	❑ Yes ❑ No	ai.	Paralysis/weakness	❑ Yes ❑ No			
r.	Allergies	❑ Yes ❑ No	aj.	High blood pressure	❑ Yes ❑ No			

30. Have you used tobacco or other sources of nicotine at any time within the last three years? ❑ Yes ❑ No
31. Has your weight increased or decreased more than 10 pounds within the last year? ❑ Yes ❑ No
32. In the last 60 days, have you taken any prescription medication, nonprescription medication or been prescribed any medication? ❑ Yes ❑ No

Question #	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery	Doctors & Hospitals with Addresses

(Use additional sheets if needed)

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PART II.

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.

33. Within the last 5 years have you had or been advised to have a surgical operation or hospitalization? ❑ Yes ❑ No
34. Have you ever received or requested benefits or payments because of an injury or illness or disability? ❑ Yes ❑ No
35. Within the last 5 years have you had x-rays, electrocardiograms, blood studies, colonoscopy or other diagnostic tests? ❑ Yes ❑ No
36. Has a parent and/or a sibling ever had diabetes, heart disease, or cancer? ❑ Yes ❑ No
37. Within the last 5 years have you had any procedures, examination or tests recommended which have not been completed? ❑ Yes ❑ No
38. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other drugs? ❑ Yes ❑ No
39. Within the last 5 years have you received medical treatment, attended a program or been counseled for alcohol or drug abuse or been advised by a member of the medical profession to reduce the use of alcohol? ❑ Yes ❑ No

Question #	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery	Doctors & Hospitals with Addresses

(Use additional sheets if needed)

40. To the best of your knowledge, are you now in good health and free from mental or physical impairment, abnormality, injury or disease, except as described in this application? ❑ Yes ❑ No *If "No" please provide additional details below.*

_____

_____

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 this application shall form the basis of the issuance of any coverage hereunder, 3) That in the event that You, the Loss Payee, the Owner or any person on Your behalf commits fraud, a misstatement or concealment either in the application or by any other statement, this Certificate may become void and no benefits will 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, 5) I have read or had read to me and understand each of the questions and statements on this entire application, and 6) No one has prevented me from spending as much time as I felt was necessary to understand this application.

_____ _____

Signature of Insured Date

Policy Owner *(if not Insured)*

_____ _____

Name Title

_____ _____

Signature Date

Disability Division

Key Person Insurance Questionnaire

Name of Key Person: First _____ Middle _____ Last _____

Occupational Duties:
(Please be precise) _____

_____

_____

What does this person do that another person cannot do? _____

_____

_____

What financial loss would the firm suffer if this Key Person were disabled? _____

_____

How long has this Key Person been working for the firm? _____

_____

Gross salary, bonuses and commissions over the last three years:

*US$*_____ *US$*_____ *US$*_____
(Current) (Last Year) (Two Years Ago)

Firm Name: _____

Type of Business: _____ Number of Employees: _____

Is the Key Person an owner of the firm: ❑ Yes ❑ No What is the % of ownership?_____

What existing coverage is currently in force on the Key Person in which the firm is the beneficiary of any benefits of the insurance? Death (face amount): $_____ Disability: $_____

What is the basis for selecting these amounts of insurance? _____

_____

_____

Net Revenue of the firm over the past three years:

US$* _____ *US$ _____ *US$* _____
(Current) (Last Year) (Two Years Ago)

Net profit/loss of the firm over the past three years:

US$* _____ *US$ _____ *US$* _____
(Current) (Last Year) (Two Years Ago)

Is the Key Person or the firm a party to any legal proceeding at this time? ❑ Yes ❑ No If yes, provide details.

_____

Corporate Officer Information:

Name: _____ Title: _____

Signature: _____ Date: _____

Petersen International Underwriters

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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
Last Four of Social Security Number	Email
Legal Representative*	Relationship

**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 _____

PETERSEN® INTERNATIONAL UNDERWRITERS

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