

# APPLICATION FOR DISABILITY INSURANCE

to: **PETERSEN INTERNATIONAL UNDERWRITERS**

23929 Valencia Blvd., Suite 215, Valencia, California 91355 • (800) 345-8816

*Underwritten by Certain Underwriters at Lloyd's*

**PART I**

1. Full Name of Proposed Insured:	2 a. Sex:	b. Age:
3a. Occupation :	c. Date of Birth:	
b. Material duties which account for the majority of your income:	d. Place of Birth:	
c. Substantial duties which account for most of your work time:	e. Soc. Sec. No.:	
4a. Name & Address of Employer:	b. Length of service:	
5. Residence Address:	c. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Send Notices to: <input type="checkbox"/> Business <input type="checkbox"/> Residence <input type="checkbox"/> Other	Phone Number:	
7. Your former occupation, if changed within 2 years:		

*If yes is answered for any of the questions 8 through 11, give details in remarks (No. 21)*

8. Is foreign travel or residence contemplated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever engaged in hazardous sports or hobbies such as parachuting, auto or motorcycle racing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you had your driver's license suspended or revoked during the past three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever had life, health or accident insurance declined, postponed, cancelled, rated or modified, or renewal or reinstatement of such refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No

12a. List below all life, medical and disability insurance for which you are presently applying, have in force, or are applying to reinstate. Include all individual, group, mortgage and credit plans. (If none, please indicate.)

Insurer	Date of Issue	Life Face Amount	Disability Monthly Benefit	Disability Lump Sum	Benefit Period	Personal	Business	Premium Payor

12b. Does your employer provide any disability benefits or salary continuation benefits? If yes, provide details	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you covered under a state disability program? (If yes, give full details in No. 12)	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>14. <b>Section I – TTD - Accident and Sickness Temporary Total Disability</b></p> <p><input type="checkbox"/> Personal Disability <input type="checkbox"/> Overhead Expense <input type="checkbox"/> Key Person</p> <p><input type="checkbox"/> Loan Indemnification <input type="checkbox"/> _____</p> <p>Monthly Benefit Requested US\$ _____</p> <p>Elimination Period Requested _____ days</p> <p>Benefit Period Requested _____ months</p> <p><input type="checkbox"/> Optional Residual <input type="checkbox"/> Optional COLA</p>	<p>16. Are you terminating any existing policies in order to qualify for the policy (or policies) now applied for? (If yes, give details with termination dates in Remarks, No. 21) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>17. Who will pay premium on policy?</p> <p>18. Policy Owner (if other than insured):</p> <p>19. Loss Payee (if other than insured):</p> <p>20. Loss Payee's IRS Account Number:</p> <p>21. Remarks:</p>
<p>15. <b>Section II – PTD - Accident and Sickness Permanent Total Disability</b></p> <p><input type="checkbox"/> Personal Disability <input type="checkbox"/> Key Person</p> <p><input type="checkbox"/> Loan Indemnification <input type="checkbox"/> Buy/Sell <input type="checkbox"/> _____</p> <p>Elimination Period Requested _____ months</p> <p>Principal Sum Requested US \$ _____</p> <p>OR Buy/Sell Installment as follows:</p> <p>Monthly Benefit Requested US\$ _____</p> <p>Elimination Period Requested _____ days</p> <p>Benefit Period Requested _____ months</p>	

**Answers to questions 22 a, b, & c are to be as reported on your 1040 USA Tax return**

22. a. What were your earnings from your occupation or profession last year: (Gross income less business expenses, but before taxes) US\$ \_\_\_\_\_

b. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (circle items) US\$ \_\_\_\_\_

c. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? Is this included in 22a?  Yes  No US\$ \_\_\_\_\_

Documentation of figures shown in 22 (a) through (c) may be needed for underwriting or claim servicing. Such documentation may include copies of individual or business corporate income tax returns, and/or W-2.

**IT IS UNDERSTOOD AND AGREED**

1. that all answers to the above questions, to the best of my knowledge and belief, are complete and true.
2. that all answers to the above questions, together with this application, shall form the basis of the issuance of any coverage hereunder
3. that in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on both sides of this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
4. the insurance hereunder applied for shall take effect on the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.

\_\_\_\_\_  
Date

060106

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Applicant-Purchaser if not Proposed Insured

# APPLICATION FOR DISABILITY INSURANCE

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**PART II**

23. a. Name and address of your personal physician (if none, please indicate): \_\_\_\_\_

b. Date and reason you last consulted a physician, psychotherapist, psychologist or other healthcare provider: \_\_\_\_\_

c. What treatment was given or medication prescribed? \_\_\_\_\_

d. If the consultation was for a checkup, did symptoms, disease, illness or injury prompt the checkup? (If yes, explain in No. 28)  Yes  No

24. a. Your height _____ ft. _____ in. Your weight _____ lbs.	b. How much has your weight changed in the last year? <input type="checkbox"/> None <input type="checkbox"/> Gain lbs. <input type="checkbox"/> Loss lbs. _____ lbs.	c. Marital status: _____
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25. Have you, to the best of your knowledge ever been treated for or had any indication of the following?

- |   |   |
|---|---|
| a. Disorder of eyes, ears, nose or throat? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>b. Headaches, fainting, unconsciousness, convulsions, concussions, paralysis, or any disorder of the brain or nervous system? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>c. Tuberculosis, asthma, or any disorder of the lungs or respiratory system? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>d. Chest pain, high blood pressure, heart murmur, or any disorder of the heart, spleen, blood, blood vessels or circulatory system? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>e. Disorder of the digestive system including stomach, intestines or bowel, liver, rectum, appendix, or gall bladder? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>f. Disorder of genito-urinary system including kidneys, bladder or any other urinary disorder? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> | g. Rheumatism, gout, arthritis or any deformity or disorder of the spine, muscles, bones or joints? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>h. Diabetes, disorder of the thyroid, pancreas or lymph nodes, or any disorder of the glands? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>i. Cancer, tumor, cyst or growth? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>j. Any allergies of any sort or disorders of the skin? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>k. Hernia, or any disorder of the reproductive system? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>l. Are you now pregnant? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>m. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told you had AIDS or ARC (AIDS related complex)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span><br>n. Any physical disorder, injury, or abnormality within the last 5 years, not disclosed in the answers above (No. 25 a-m) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> |
|---|---|

26. a. Within the last 5 years have you ever had an injury or sickness which was the basis for an insurance claim?  Yes  No
- b. Within the last 5 years have you ever had or been advised to have a surgical operation or hospitalization?  Yes  No
- c. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests?  Yes  No
- d. Are you now taking medication?  Yes  No
- e. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness?  Yes  No
- f. Have you ever received treatment or joined an organization for alcoholism or drug dependence?  Yes  No
- g. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other similar drugs?  Yes  No
- h. Have you ever used tobacco at any time within the past 12 months?  Yes  No

27. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described above? (If "No", explain fully in Remarks No. 29)  Yes  No

28. Give complete details below to any questions above which are answered "yes"

Question Number	Details of Conditions or Treatment	Date and Duration	Details and Degree of Recovery	Doctors and Hospitals With addresses

29. Remarks:

**IT IS UNDERSTOOD AND AGREED**

1. that all answers to the above questions, to the best of my knowledge and belief, are complete and true.
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3. that in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on both sides of this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
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\_\_\_\_\_  
Signature of Proposed Insured

Date

\_\_\_\_\_  
Signature of Applicant-Purchaser if not Proposed Insured

# **Petersen International Underwriters Privacy Policy Statement**

## **Petersen International Underwriters**

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

### **Information We Collect**

We collect non-public information about you from numerous sources including, but not limited to:

- a) Information we receive from you on applications and other forms;
- b) Information about your transactions with our affiliates, others or us;
- c) Information we receive from consumer-reporting agencies; and
- d) Financial and medical sources.

### **Information We Disclose**

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

### **Right to access or correct your personal information**

You have a right to request access to or correction of your personal information in our possession.

### **Confidentiality and Security**

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

### **Contacting Us**

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: [piu@piu.org](mailto:piu@piu.org)



**PETERSEN INTERNATIONAL UNDERWRITERS**

23929 Valencia Boulevard, Suite 215, Valencia, California 91355

(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604

Website: <http://www.piu.org> E-Mail: [piu@piu.org](mailto:piu@piu.org)

**AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION**

**This Authorization complies with the HIPAA Privacy Rule**

I, \_\_\_\_\_ hereby acknowledge this Authorization to Release Health  
(Proposed Insured/Patient)  
Related information.

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment which includes, but is not limited to:

- Physicians
- Hospitals
- Clinics
- Medically related facilities
- Rehabilitation facilities
- Laboratories
- Other/Specific: \_\_\_\_\_

\_\_\_\_ Proposed Insured/Patient Initials

to disclose my medical records to Petersen International Underwriters (or its assigned 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, but not be limited to:

- Patient Histories
- Progress notes
- Test results
- X-rays
- Psychiatric Evaluations
- Drug and/or Alcohol Treatment information
- HIV Test Results and/or
- Other diagnostic information

\_\_\_\_ Proposed Insured/Patient Initials

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature (if by someone other than the Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

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.

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  
23929 Valencia Boulevard, Suite 215  
Valencia, California 91355

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 the Authorization is signed unless a different date is specified here: \_\_\_\_\_.

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature (if by someone other than the Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship



# DISABILITY DIVISION

## Keyperson Insurance Questionnaire

Name of Keyperson: 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 employee were disabled? \_\_\_\_\_  
\_\_\_\_\_

How long in the employment of the firm: \_\_\_\_\_

Gross salary, bonuses and commissions over last three years:  
US\$ \_\_\_\_\_ US \$ \_\_\_\_\_ US\$ \_\_\_\_\_  
(CURRENT) (LAST YEAR) (TWO YEARS AGO)

Firm Name: \_\_\_\_\_

Type of Business: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Is Keyperson an owner of the firm?  Yes  No What is % of Ownership? \_\_\_\_\_

What existing coverage is currently in force on the Keyperson 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 profit/loss of firm over past three years:

US\$ \_\_\_\_\_ US\$ \_\_\_\_\_ US\$ \_\_\_\_\_  
(CURRENT) (LAST YEAR) (TWO YEARS AGO)

Are there other Keypersons in the firm?  Yes  No How many? \_\_\_\_\_ Are others to be insured?  Yes  No

Are you or the company a party to any legal proceeding at this time?  YES  NO If "yes", furnish all details. \_\_\_\_\_  
\_\_\_\_\_

Form completed by:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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