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:
c. Date of Birth:
d. Place of Birth:
e. Soc. Sec. No.

3a. Occupation :
b. Material duties which account for the majority of your income:
c. Substantial duties which account for most of your work time:

4a. Name & Address of Employer:
b. Length of service:
c. Are you actively at work? ❑ Yes ❑ No

5. Residence Address:
6. Send Notices to: ❑ Business ❑ Residence ❑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? ❑ Yes ❑ No
9. Have you ever engaged in hazardous sports or hobbies such as parachuting, auto or motorcycle racing? ❑ Yes ❑ No
10. Have you had your driver's license suspended or revoked during the past three years? ❑ Yes ❑ No
11. Have you ever had life, health or accident insurance declined, postponed, cancelled, rated or modified, or renewal or reinstatement of such refused? ❑ Yes ❑ 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 ❑ Yes ❑ No

13. Are you covered under a state disability program? (If yes, give full details in No. 12) ❑ Yes ❑ No

14. **Section I – Monthly Benefit Plan**

❑ Personal Disability ❑ Overhead Expense ❑ Key Person
❑ Bank Loan Indemnification ❑Buy/Sell ❑ ____________

Accident and Sickness Temporary Total Disability

Monthly Benefit Requested $ ________________
Elimination Period Requested ________________ days
Benefit Period Requested ________________ months
❑ Optional Residual ❑ Optional COLA

Section II – Lump Sum Benefit Plan

❑ Personal Disability ❑ Key Person
❑ Bank Loan Indemnification ❑Buy/Sell ❑ ____________

Accident and Sickness Permanent Total Disability

Elimination Period Requested ________________ months
Principal Sum Requested $ ________________

15. 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 ❑ Yes ❑ No
16. Who will pay premium on policy?
17. Beneficiary:
Relationship:
18. Policy Owner (if other than insured):
19. Loss Payee (if other than insured):
20. Loss Payee's IRS Account Number:
21. Remarks

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 to complete underwriting. Such documentation will be copies of individual or corporate income tax returns, or W-2 forms.

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.
5. **Binding Arbitration - Waiver of Right to Trial by Jury: I understand and agree that any dispute concerning this insurance must be submitted to binding arbitration if the amount in dispute exceeds the jurisdictional limits of small claims court and is not resolved with a formal review by Underwriters. I understand and agree that this is a waiver of my and Underwriters rights to a trial by jury.**

Date: ________________________________

____
Signature of Proposed Insured

____
Signature of Applicant-Purchaser if not Proposed Insured

06/03

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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. ______ ______ lbs.

b. How much has your weight changed in the last year? ❑ None ❑ Gain lbs. ❑ Loss lbs. ______ lbs.

c. Marital status: ______

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? ❑ Yes ❑ No

b. Headaches, fainting, unconsciousness, convulsions, concussions, paralysis, or any disorder of the brain or nervous system? ❑ Yes ❑ No

c. Tuberculosis, asthma, or any disorder of the lungs or respiratory system? ❑ Yes ❑ No

d. Chest pain, high blood pressure, heart murmur, or any disorder of the heart, spleen, blood, blood vessels or circulatory system? ❑ Yes ❑ No

e. Disorder of the digestive system including stomach, intestines or bowel, liver, rectum, appendix, or gall bladder? ❑ Yes ❑ No

f. Disorder of genito-urinary system including kidneys, bladder or any other urinary disorder? ❑ Yes ❑ No

g. Rheumatism, gout, arthritis or any deformity or disorder of the spine, muscles, bones or joints? ❑ Yes ❑ No

h. Diabetes, disorder of the thyroid, pancreas or lymph nodes, or any disorder of the glands? ❑ Yes ❑ No

i. Cancer, tumor, cyst or growth? ❑ Yes ❑ No

j. Any allergies of any sort or disorders of the skin? ❑ Yes ❑ No

k. Hernia, or any disorder of the reproductive system? ❑ Yes ❑ No

l. Are you now pregnant? ❑ Yes ❑ No

m. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told you had AIDS or ARC (AIDS related complex)? ❑ Yes ❑ No

n. Any physical disorder, injury, or abnormality within the last 5 years, not disclosed in the answers above (No. 25 a-m) ❑ Yes ❑ No

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 advise 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.
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.
5. **Binding Arbitration - Waiver of Right to Trial by Jury: I understand and agree that any dispute concerning this insurance must be submitted to binding arbitration if the amount in dispute exceeds the jurisdictional limits of small claims court and is not resolved with a formal review by Underwriters. I understand and agree that this is a waiver of my and Underwriters rights to a trial by jury.**

Signature of Proposed Insured

Date: ______

Signature of Applicant-Purchaser if not Proposed Insured

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

AUTHORIZATION TO RELEASE PERSONAL INFORMATION
HIPPA Compliant

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give to Petersen International Underwriters, Inc., any and all such information or to any agency authorized by Petersen International Underwriters, Inc. to collect such information.

I UNDERSTAND the purpose of this Authorization is to allow Petersen International Underwriters, Inc., to determine eligibility for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by Petersen International Underwriters, Inc., to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I UNDERSTAND that I may revoke this Authorization, except to the extent that Petersen International Underwriters, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to Petersen International Underwriters Inc.. Any such revocation may also have an impact upon my Underwriting or claims processing.

I UNDERSTAND that I can obtain a complete copy of Petersen International Underwriters Inc. Privacy Policy either on Petersen International Underwriters, Inc. website or by contacting them directly and asking for a copy.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signed this ______________________________ day of __________________________ 20__________

____
Signature of Proposed Insured

LIFE & DISABILITY DIVISION

Confidential Financial Statement

Proposed Insured: FIRST ____________________ MIDDLE ____________________ LAST ____________________

The following financial disclosure is made for the purpose of establishing insurability in connection with a pending application on myself. This is furnished as a true and accurate statement of my financial condition as of:

____________________, 20 __________

	Column (A) CURRENT YTD	Column (B) LAST YEAR	Column (C) TWO YEARS AGO
I. **ANNUAL INCOME** from occupation or profession (Show adjusted gross income before taxes and after business expenses. List commission and bonus income separately.)	US$ ________	US$ ________	US$ ________
Commission Income	US$ ________	US$ ________	US$ ________
Bonuses	US$ ________	US$ ________	US$ ________
Pension & Profit Sharing Contributions	US$ ________	US$ ________	US$ ________
Royalty Income	US$ ________	US$ ________	US$ ________
II. **OTHER INCOME**			
Dividends and Interest	US$ ________	US$ ________	US$ ________
Net Real Estate Income before Depreciation (Gross income less expenses and payments)	US$ ________	US$ ________	US$ ________
Other (Please specify)			
________________________________	US$ ________	US$ ________	US$ ________
________________________________	US$ ________	US$ ________	US$ ________
III. **TOTAL CURRENT NET WORTH** (Please itemize below)	US$ ______________________________		
Cash, Savings, Stocks, Bonds		US$ ________	
Personal Property (e.g. furnishings, jewelry, car, boat, etc.)		US$ ________	
Personal Residence (fair market value less mortgages, loans)		US$ ________	
Other Real Estate (fair market value less mortgages, loans)		US$ ________	
Business Interest (show fair market value less mortgages, loans)		US$ ________	
Other (Please specify)			
________________________________		US$ ________	
________________________________		US$ ________	
IV. **ADDITIONAL CLARIFYING INFORMATION**			

I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

______________________________ Date

______________________________ Signature of Proposed Insured

PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Blvd., Suite 215 • Valencia, California 91355

Tel (661) 254-0006 - Fax (661) 254-0604 - (800) 345-8816

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.).

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