

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:	c. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Residence Address:		
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: <i>If yes is answered for any of the questions 8 through 11, give details in remarks (No. 21)</i>		
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 Yes No

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

<p>14. Section I – Monthly Benefit Plan</p> <p><input type="checkbox"/> Personal Disability <input type="checkbox"/> Overhead Expense <input type="checkbox"/> Key Person</p> <p><input type="checkbox"/> Bank Loan Indemnification <input type="checkbox"/> Buy/Sell <input type="checkbox"/> _____</p> <p>Accident and Sickness Temporary Total Disability</p> <p>Monthly Benefit Requested \$ _____</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>Section II – Lump Sum Benefit Plan</p> <p><input type="checkbox"/> Personal Disability <input type="checkbox"/> Key Person</p> <p><input type="checkbox"/> Bank Loan Indemnification <input type="checkbox"/> Buy/Sell <input type="checkbox"/> _____</p> <p>Accident and Sickness Permanent Total Disability</p> <p>Elimination Period Requested _____ months</p> <p>Principal Sum Requested \$ _____</p>	<p>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) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Who will pay premium on policy?</p> <p>17. Beneficiary:</p> <p>Relationship: _____</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>
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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

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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? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Headaches, fainting, unconsciousness, convulsions, concussions, paralysis, or any disorder of the brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Tuberculosis, asthma, or any disorder of the lungs or respiratory system? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Chest pain, high blood pressure, heart murmur, or any disorder of the heart, spleen, blood, blood vessels or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disorder of the digestive system including stomach, intestines or bowel, liver, rectum, appendix, or gall bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Disorder of genito-urinary system including kidneys, bladder or any other urinary disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Rheumatism, gout, arthritis or any deformity or disorder of the spine, muscles, bones or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No
h. Diabetes, disorder of the thyroid, pancreas or lymph nodes, or any disorder of the glands? <input type="checkbox"/> Yes <input type="checkbox"/> No
i. Cancer, tumor, cyst or growth? <input type="checkbox"/> Yes <input type="checkbox"/> No
j. Any allergies of any sort or disorders of the skin? <input type="checkbox"/> Yes <input type="checkbox"/> No
k. Hernia, or any disorder of the reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No
l. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
n. Any physical disorder, injury, or abnormality within the last 5 years, not disclosed in the answers above (No. 25 a-m) <input type="checkbox"/> Yes <input type="checkbox"/> 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.
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Date: _____ Signature of Proposed Insured
Signature of Applicant-Purchaser if not Proposed Insured

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(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

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