



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:
\$ _____ \$ _____ \$ _____
(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:
\$ _____ \$ _____ \$ _____
(CURRENT) (LAST YEAR) (TWO YEARS AGO)

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

Form completed by:

Name: _____ Title: _____

Signature: _____ Date: _____

Petersen International Underwriters

Lloyd's Correspondents

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