APPLICATION FOR DISABILITY INSURANCE

Stan Patterson - Broker # 17696

info@internationalhealthins.com - Direct: 417-335-6777 - Fax: 775-796-2582

PART I

1. Full Name of Proposed Insured:	2 a. Sex:
	b. Date of Birth:
3a. Occupation :	c. Place of Birth:
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. 19)

8. Is foreign travel or residence contemplated?	❑ Yes ❑ No
9. Do you ever engage in hazardous sports or hobbies?	❑ 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 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	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. 19)	❑ Yes ❑ No

14.
❑ Personal Disability ❑ Overhead Expense ❑ Key Person
❑ Loan Indemnification ❑ _____

Section I (if applicable)
Monthly Benefit Requested US$ _____
Elimination Period Requested _____ days
Benefit Period Requested _____ months
❑ Optional Residual ❑ Optional COLA

Section II (if applicable)
Principal Sum Requested US $ _____
Principal Sum Elimination Period _____ months

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. Policy Owner (if other than insured):

18. Loss Payee (if other than insured):

19. Remarks:

Answers to questions 20 a, b, & c are to be as reported on your 1040 USA Tax return

20. 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 20a? ❑ Yes ❑ No US$ _____
Documentation of figures shown in 20 (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 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.

_____
Signature of Proposed Insured

_____
Date

_____
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.	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 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.
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 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.

_____
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 HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured ("Applicant") _____Date of Birth_____

I specifically authorize the following Healthcare Provider (name of provider)_____ in addition to 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, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/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, information and/or 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. 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 refuse to sign this authorization and that such refusal to sign will not be a condition to affect the ability of the Applicant to obtain treatment. 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.

_____ _____
Signature of Proposed Insured/Patient Date

_____ _____
*Signature of Legal Representative (if other than Proposed Insured/Patient) Date

_____
Printed Name and Relationship

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

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:

_____, 200 _____

	Column (A) CURRENT YTD 200___	Column (B) LAST YEAR 200___	Column (C) TWO YEARS AGO 200___
I. **ANNUAL INCOME** from occupation or profession			
(Show gross income less business expenses but, before			
taxes. 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**			
V. **ARE YOU A PARTY TO ANY LEGAL PROCEEDING AT THIS TIME?** ❒ YES ❒ NO If "yes", furnish all details.			

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
www.piu.org piu@piu.org

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