International & Special Use Term Life

PETERSEN
INTERNATIONAL UNDERWRITERS

For

U.S. Dollar Term Life Insurance for use when there is an international insurable interest involved.

Uses

- Employees of Foreign National Firms
- International Asset Protection
- International Business Travel
- Short Term Needs
- Special Assignments

The Patterson Agency, Inc.
Stan Patterson, President

Telephone: 800-641-4614
Fax: 775-796-2582
www.internationalhealthins.com
info@internationalhealthins.com

International & Special Use Term Life

In terms of business partnerships, trade opportunities and merging companies, the world gets smaller everyday. This means that people travel more frequently which makes International Term Life Insurance protection increasingly important.

Unexpected complications that are not covered by traditional insurance carriers can occur while travelling or living abroad. We have developed the International & Special Use Term Life plan to make sure those in need are covered in case the unexpected happens.

Each person's situation is different and we will develop a plan with flexible term lengths and high benefit limits to fit your needs. From business people to journalists, the International & Special Use Term Life plan will ease the worries of those traveling or living abroad.

As international travel becomes progressively more common, the necessity for International Term Life grows. Our plan will financially protect individuals, their families and their businesses anywhere in the world they may travel.

Policy Features:

- **Available from a 1-month to a maximum 10-year policy term**
- **Requalifying is not required during the policy term**

Optional Riders:

- **War & Terrorism coverage**
- **Hazardous Sports & Activities Coverage**

Take the Case of...

A man who is planning to serve as a missionary for the next three years in southeast Asia. He is looking for $500,000 of coverage for estate planning and loss of future income purposes in order to provide financial security to his family. We easily accomodated him with an International Term Life policy that covered him for the 3 years he would be out of the United States.

International Term Life Insurance Application

Return to: The Patterson Agency, Inc.
info@internationalhealthins.com • fax: 775-796-2582 • phone: 417-544--1799

NO insurance is in force until this application has been accepted and approved by underwriters and the first premium has been paid. Before any question is answered, please read carefully the declaration at the end of this application form, which must be signed and dated. Please ensure that all questions are answered fully and correctly by the person to be insured. Any question left unanswered will delay the assessment of the application for insurance.

Personal Information

Proposed Insured: First _____ Middle _____ Last _____

Date of Birth: _____ / _____ / _____ Sex: ❑Male ❑Female Height: _____ Weight: _____

Citizenship: _____ Place of Birth: _____ Nationality: _____

Marital Status: _____ Number of Dependents: _____

SS# or Passport#: _____ Country Issued: _____

E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____

Address: Number & Street _____

City _____ State _____ Zip Code _____ Country _____

Employer: Name _____ Number & Street _____

City _____ State _____ Zip Code _____ Country _____

Requested Term: Years _____ Requested Sum Insured: $ _____

Beneficiary: _____ Relationship: _____

Contingent Beneficiary: _____ Relationship: _____

Policy Owner: First _____ Middle _____ Last _____

Address: Number & Street _____

City _____ State _____ Zip Code _____ Country _____

Insurable Interest: _____

Occupation Information

Occupation: _____ Annual Income From Occupation: _____

Net Worth: _____ Any Other Income and Source: _____

Do your occupational duties involve any of the following: (if yes please provide details)

1. Working at heights? ❑ Yes ❑ No
2. Working offshore? ❑ Yes ❑ No
3. Diving or fishing? ❑ Yes ❑ No
4. Military involvement? ❑ Yes ❑ No
5. Any aviation exposure other than on regularly scheduled airlines? ❑ Yes ❑ No
6. Mining or working underground? ❑ Yes ❑ No
7. The use of special safety precautions? ❑ Yes ❑ No
8. Any activity that might be considered hazardous? ❑ Yes ❑ No

Questions # _____ _____

Questions # _____ _____

Questions # _____ _____

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Premium Frequency Requested: ❑ Annual ❑ Semi annual ❑ Quarterly
Requested Effective Date: _____
Reasons for this insurance: _____
Is replacement of any insurance involved with this transaction: ❑ Yes ❑ No If Yes please provide details _____
_____
Do you have any other life insurance in force or intending to be put into force: ❑ Yes ❑ No

Insurer	Approximate Date of Issue	Life Insurance Sum Insured

Medical History

Primary Care Physician: Name _____
Date & Reason Last Seen: Address _____
Reason Seen _____ Date _____ Results _____

Have you ever suffered from or been diagnosed with:

9. Cyst? ❑ Yes ❑ No
10. Gout? ❑ Yes ❑ No
11. Lump? ❑ Yes ❑ No
12. Stroke? ❑ Yes ❑ No
13. Cancer? ❑ Yes ❑ No
14. Arthritis? ❑ Yes ❑ No
15. Diabetes? ❑ Yes ❑ No
16. Epilepsy? ❑ Yes ❑ No
17. Chest pain? ❑ Yes ❑ No
18. HIV / AIDS? ❑ Yes ❑ No
19. Heart disease? ❑ Yes ❑ No
20. Any operation? ❑ Yes ❑ No
21. Liver problems? ❑ Yes ❑ No
22. Hepatitis B or C? ❑ Yes ❑ No
23. Kidney problems? ❑ Yes ❑ No
24. Prostate problems? ❑ Yes ❑ No
25. Rheumatic fever? ❑ Yes ❑ No
26. Bladder problems? ❑ Yes ❑ No
27. High Blood Pressure? ❑ Yes ❑ No
28. Any disorder of the blood? ❑ Yes ❑ No
29. Any Chest or Lung disorder? ❑ Yes ❑ No
30. Sexually transmitted disease? ❑ Yes ❑ No
31. X-Ray, MRI or other special tests? ❑ Yes ❑ No
32. Any Stomach or Bowel complaints? ❑ Yes ❑ No
33. Disorder of the brain or spinal cord? ❑ Yes ❑ No
34. Anxiety, Depression, or other Mental or Nervous disorder? ❑ Yes ❑ No
35. Dizziness, convulsions, neurological disorder? ❑ Yes ❑ No

Questions # _____ _____
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Questions # _____ _____

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36. Has your weight changed within the last 12 months? ❑ None ❑ Gain ❑ Loss • Amount _____
37. Have you used any tobacco within the last 12 months? ❑ Yes ❑ No
38. How much alcohol do you consume per week? ❑ None ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7-8 ❑ 9-10 ❑ 11+
39. Have you ever been medically advised to reduce your alcohol consumption? ❑ Yes ❑ No
40. Have you ever used drugs on a recreational basis? ❑ Yes ❑ No
41. Have you consulted any doctor, hospital, or clinic within the last 5 years, other than for clearly minor conditions such as colds, flu, etc.? ❑ Yes ❑ No
42. Are you taking any medicine or drugs whether or not prescribed by a physician or receiving any treatments of any kind? ❑ Yes ❑ No
43. Have any of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer or a nervous disorder? ❑ Yes ❑ No
44. Has any application for insurance on your life or health been declined, withdrawn by yourself or accepted with special terms? ❑ Yes ❑ No
45. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as previously described? ❑ Yes ❑ No
46. Have you or any business owned in whole or in part by you ever been in Bankruptcy? ❑ Yes ❑ No
47. Do you engage in any hazardous sports or pastimes such as a private aviation, motor sports, diving, skiing or boarding, etc.? ❑ Yes ❑ No
48. Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australia? ❑ Yes ❑ No

Additional Details: _____
_____
_____
_____

Important Notes – Please note that your answers to the questions on this application form will be used to assess the ability for us to offer you insurance. All material facts must be disclosed since part or all of the benefit that this insurance is to provide might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of this application. If you are unsure whether a particular fact is material you should disclose it. **Insurance coverage will not start until we have accepted your application and the first premium has been paid.** If you have a birthday while your application is being underwritten, the terms may differ from those originally quoted. We may ask you to contact your doctor to speed up the completion of reports that we may have requested. Both Petersen International Underwriters and our Life Underwriters have Confidentiality Policies in place. If you require a copy of such please contact our office.

Declarations – It is understood and agreed that all the answers to the above questions, to the best of my knowledge and belief, are true and complete; that all answers to the above questions, together with this application shall form the basis of the issuance of any coverage hereunder; 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 in part or in whole with benefits not being payable; and the insurance hereunder applied for shall take effect on the date set forth on the certificate of insurance, 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 the application and the effective date of the certificate.

I have read the application, Important Notes and Declarations.

Signature of life to be insured: _____ Date: _____
Signature of Policy Owner: _____ Date: _____

Authorization to Release Personal Information

In Compliance with HIPAA & Financial Privacy Regulation

I, the proposed insured, authorize 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, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/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, 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. Additionally, it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. 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.

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 that I have signed this Authorization.

Printed Name of Proposed Insured	Date of Birth
Signature of Proposed Insured	Date
*Printed Name of Legal Representative (if other than Proposed Insured)	Relationship to the Proposed Insured
Signature of Legal Representative (if other than Proposed Insured)	Date

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

Please Email, Fax or Mail This Form To:

PETERSEN
INTERNATIONAL UNDERWRITERS
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800.345.8816 toll-free • 661-254-0604 fax
www.piu.org • piu@piu.org