DISABILITY INSURANCE SHORT FORM APPLICATION

To: PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondents

23929 Valencia Blvd., Suite 215 • Valencia, CA 91355-2186 • Tel (800) 345-8816 • Fax (661) 254-0604

Name ______________________ Date of Birth ____________

Occupation ______________________ Height ________ Weight ________ Sex _____

1. a. What were your earnings from your 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 1a? ☐ YES ☐ NO US$ __________

2. Have you consulted or been treated by a licensed physician, psychotherapist, psychologist, or other health care provider in the last 12 months, or from inception date of your current expiring coverage, whichever is longer? ☐ YES ☐ NO
   If yes, whom did you see? ______________
   Address and phone number of Doctor seen ______________
   For what were you treated by this physician or healthcare provider? ______________
   What were the results from this consultation or treatment? ______________
   If more than one physician was seen please explain on reverse side.
3. Have you received treatment or been advised to seek treatment for drug or alcohol abuse? ☐ YES ☐ NO
4. Have you filed a claim for disability benefits in the past 5 years? ☐ YES ☐ NO
   If yes, what was the nature of the accident or sickness? ______________
   Date disability occurred ______________
   Time lost from work ______________
5. To the best of your knowledge, are you now in good health and free from mental or physical impairment, abnormality injury or disease? ☐ YES ☐ NO
6. Has any application been made by you within the last year for accident, sickness, hospitalization, major medical or life insurance been declined, postponed or increased in rate? ☐ YES ☐ NO
7. Are you presently working full-time? ☐ YES ☐ NO
8. Are you now taking medication? ☐ YES ☐ NO
   meds & reason taken ______________

9. Are you presently applying, have in force, or are applying to reinstate any disability insurance other than this application? ☐ YES ☐ NO
   If yes please list below (Include all individual, group, mortgage and credit plans)

Insurer	Approximate Date of Issue	Personal Disability Monthly Benefit	Business Overhead Monthly Benefit	Buy/Sell Disability

10. Does your employer provide any disability benefits or salary continuation benefits? If yes, please provide details. ☐ YES ☐ NO
11. Are you covered under a state disability program? (If yes, give full details in No. 9) ☐ **YES** ☐ **NO**

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 such questions, together with this agreement and any prior underwriting information, 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 the questions on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits will be payable.
4. that except as amended by the answers to the above questions, any answers shown on any prior application for this coverage signed and dated by me are expressly reaffirmed.
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.**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, to give to the certain underwriters at Lloyd's of London or its legal representative any such information.

AUTHORIZATION

Date ______________________

____
Signature of Proposed Insured

____
Signature of Applicant-Purchaser if not Proposed Insured

Phone: ______________ Applicant's Fax: ______________ Applicant's e-mail: ______________
Is this a confidential fax ☐ Yes ☐ No

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

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