



APPLICATION FOR DISABILITY INSURANCE  
PETERSEN INTERNATIONAL UNDERWRITERS

Producer #: \_\_\_\_\_ PART I.

**PERSONAL INFORMATION**

Applicant's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail: \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation: \_\_\_\_\_ Daily Duties: \_\_\_\_\_

Specialty: \_\_\_\_\_ Length of Service: \_\_\_\_\_

Policy Owner: \_\_\_\_\_ Loss Payee: \_\_\_\_\_

*(If other than Insured)*

*(If other than Insured)*

Premium Payor:  Applicant  Employer  Other: \_\_\_\_\_

Payment Mode:  Multi-Year Prepay  Annual  Semi-Annual  Quarterly  Monthly (EFT/CC)

Bill To:  E-mail  Applicant's Address  Employer - Attention: \_\_\_\_\_

Other: \_\_\_\_\_

1. Are you actively at work?  Yes  No

***If "Yes" is answered for any of the following questions please provide full details in the space below.  
If there is not sufficient space, please attach your answers on a separate sheet.***

2. Is foreign travel or residence contemplated?  Yes  No

3. Has your occupation changed within the last 2 years?  Yes  No

4. Do you ever engage in hazardous sports or hobbies?  Yes  No

5. Are you a party to any legal proceeding at this time?  Yes  No

6. Are you aware of any fact that could change your occupation or financial stability?  Yes  No

7. Have you ever been convicted of any felony or misdemeanor or do you have any charges pending?  Yes  No

8. Have you or any business of which you had any ownership in filed for bankruptcy in the last 5 years?  Yes  No

9. Have you had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated?  Yes  No

10. Have you ever had disability, life, health, or accident insurance declined, postponed, cancelled, rated, or modified, or reinstatement of such refused?  Yes  No

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE INITIAL THE FOLLOWING**

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application. \_\_\_\_\_



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PART I.

FINANCIAL INFORMATION

11. What was your gross earned income less business expenses, but before taxes from your profession?
12. What was "other income" from dividends, interest, rents, royalties, estates and trusts, etc.?
13. a) What was contributed to IRA, HR10, qualified pension or profit-sharing plan?
b) Is this included in #11? Yes No

Please indicate the type of coverage and the amount of coverage that you are applying for.

14. Personal Overhead Expense Key Person Loan Indemnification Buy/Sell Other

15. Section I - Monthly Benefits (if applicable)

Monthly Benefit requested: US\$
Elimination Period requested: Days
Benefit Period requested: Months

Section I - Optional Riders:

- Residual
COLA
Prime Flex (Loan Indemnification Only)
Salary Replacement Rider (Overhead Expense Only)

16. Section II - Lump Sum Benefit (if applicable)

Principal Sum requested: US\$
Elimination Period requested: Months

ADDITIONAL POLICY INFORMATION

17. Does your employer provide disability benefits or salary continuation benefits?
18. Please list all disability insurance (including individual, group, mortgage, and credit plans) for which you are applying, have in force, or are reinstating. If none, please indicate "None".

Table with 6 columns: Insurer, Issue Date, Personal DI Monthly Benefit, Business Overhead Monthly Benefit, Buy/Sell Disability, Other Disability

If "None" was answered for question #18, please proceed to question #20.

19. Are you terminating any existing policies listed above in order to qualify for the coverage now being applied for?
If "Yes" please indicate the coverage that is to be terminated.

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PART II.

MEDICAL INFORMATION

- 20. Primary care physician: a. Name & address: b. Date and reason last seen: c. Results of last visit:
21. Last healthcare provider seen: a. Name & address: b. Date and reason last seen: c. Results of last visit:

If "Yes" is answered for any of the following questions please provide full details in the space below.
If there is not sufficient space, please attach your answers on a separate sheet.

- 22. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?
a. Eyes, b. Ears, c. Nose, d. Cyst, e. Gout, f. Knees, g. Back/spine/neck, h. Skin, i. Liver, j. Heart, k. Blood, l. Bones, m. Throat, n. Hernia, o. Cancer, p. Bladder, q. Muscles, r. Kidneys, s. Glands, t. Thyroid, u. Pancreas, v. Diabetes, w. Chest pain, x. Headaches, y. HIV/AIDS, z. Sleep apnea, aa. Gall bladder, ab. Convulsions/Seizures, ac. Concussions, ad. Blood vessels, ae. Lymph nodes, af. Intestinal tract, ag. Urinary system, ah. Arthritis/joints /rheumatism, ai. Nervous system, aj. Growth/tumor, ak. Unconsciousness, al. Circulatory system, am. Fainting/dizziness, an. Paralysis/weakness, ao. High blood pressure, ap. Disorder of the brain, aq. Mental/Emotional/Psychiatric, ar. Lungs, as. Asthma, at. Allergies, au. Tuberculosis, av. Respiratory system, aw. Reproductive system, ax. Digestive system/stomach, ay. Are you now pregnant?, az. Any condition not mentioned previously?

Table with 5 columns: Question #, Details of Conditions/Treatment, Date & Duration, Details and Degree of Recovery, Doctors & Hospitals with Addresses.

( Use additional sheets if needed)

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PART II.

**MEDICAL INFORMATION CONTINUED**

*If "Yes" is answered for any of the following questions please provide full details in the space below.  
If there is not sufficient space, please attach your answers on a separate sheet.*

- 23. Have you used tobacco at any time within the last three years?  Yes  No
- 24. Has your weight increased or decreased more than 10 pounds within the last year?  Yes  No
- 25. Are you now taking/using prescription medication and/or nonprescription medication?  Yes  No
- 26. In the last 60 days, have you taken any medicines which are not listed in #25?  Yes  No
- 27. Within the last 5 years have you had or been advised to have a surgical operation or hospitalization?  Yes  No
- 28. Have you ever received or requested benefits or payments because of an injury or illness or disability?  Yes  No
- 29. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests?  Yes  No
- 30. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness?  Yes  No
- 31. Within the last 5 years have you had any procedures, examination or tests recommended which have not been completed?  Yes  No
- 32. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other drugs?  Yes  No

Question #	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery	Doctors & Hospitals with Addresses

( Use additional sheets if needed)

- 33. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application?  Yes  No - If No, please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IT IS UNDERSTOOD AND AGREED:**

1. that all answers to the questions on this application, to the best of my knowledge and belief, are complete and true,
2. that all answers on 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, and
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. I have read or had read to me and understand each of the questions and statements on this entire application.
6. No one has prevented me from spending as much time as I felt was necessary to understand this application.

\_\_\_\_\_  
Signature of Applicant                      Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Policy Owner - (if not Applicant)                      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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HIPAA 05.12