



HIGH LIMIT ACCIDENT INSURANCE APPLICATION

To: PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Coverholder

Proposed Insured:

FIRST MIDDLE LAST

Residence Address:

STREET AND NUMBER

CITY STATE ZIP () DAYTIME PHONE NUMBER

Personal Information:

DATE OF BIRTH HEIGHT WEIGHT E-MAIL ADDRESS

Name of Employer:

Business Address:

STREET AND NUMBER

CITY STATE ZIP () BUSINESS PHONE NUMBER

Occupation:

Annual Earnings:

Other Insurance:

What is the total amount of other life insurance benefits in force or applying for \$

Geographical Limits:

Please indicate countries to be visited if outside of the U.S.A.:

Air Travel:

Will aviation travel be on regularly scheduled airlines? If "no," please provide details. YES NO

Name of Beneficiary:

Relationship:

Address:

Policy Owner:

Relationship:

Address:

Benefit Requested:

Sum Insured \$ (Not to exceed 10 times annual income or satisfactory justification must be submitted)

Coverage Requested:

(check one)

All-risk, 24 Hour or Common Carrier or Air Travel Only

Optional Coverages:

War or Acts of War and Terrorism

Benefits Requested:

(check one)

Accidental Death (AD) Accidental Death and Dismemberment (AD&D) Accidental Death, Dismemberment and Sudden Cardiac Arrest (AD&D & SCA - Available up to age 65)

Period of Insurance:

Number of Weeks: Effective Date:

PLEASE ANSWER ALL THE QUESTIONS

- Have you any physical defect or infirmity? YES NO
 - Is your sight or hearing defective? YES NO
 - Have you ever suffered from any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind? YES NO
 - Have you ever suffered from:
 - high blood pressure, a heart condition, rheumatic fever or diabetes? YES NO
 - a "slipped disc" or other spinal disorder, a hernia or any rheumatic or arthritic condition? YES NO
 - Have you ever been declined or accepted on special terms for life, accident or illness insurance? YES NO
 - Do you intend to engage in hazardous sports or any other pastimes that expose you to extra personal injury? YES NO
- Dates and Details to all "YES" answers above _____

DECLARATION

I declare that the above statements are true and complete, and that, apart from the matters declared above, I am in good health and ordinarily enjoy good health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctor to give this information. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that pre-existing conditions are not covered until a period of insurance of 12 months, treatment free, has elapsed.

Date: _____

Signature of Proposed Insured

Owner: _____

(if other than proposed insured)

Signature of Owner or Title and signature of Officer signing for Firm or Corporation

Applicant's Phone: Applicant's Fax: Applicant's email:



HIGH LIMIT ACCIDENT INSURANCE

ACCIDENTS – THE UNIQUE HAZARD

Sickness, with its usual warning symptoms allows some lead time to prepare for the emotional and economic consequences that follow.

ACCIDENTS STRIKE WITHOUT WARNING!

Medical and Disability Insurance often fall short of covering the costs inherent with accidental bodily injuries and inadequately compensate for the specific losses of limb, sight, speech and hearing.

Life Insurance proceeds are seldom adequate to cover the financial loss due to death.

THE ACCIDENT HAZARD IS SUFFICIENTLY UNIQUE TO MERIT SPECIFIC INSURANCE.

COVERAGE OPTIONS

SUM INSURED

\$ _____

PREMIUM

\$ _____

COVERAGE PROPOSED

24 Hour Cover Common Carrier Air Travel Only

OPTIONAL COVERAGE

War or Acts of War and Terrorism

BENEFITS PROPOSED

Accidental Death (AD) Accidental Death & Dismemberment (AD&D) Accidental Death, Dismemberment and Sudden Cardiac Arrest (AD&D + SCA - available up to age 65)

PERIOD OF INSURANCE Number of Days:

GEOGRAPHICAL LIMITS:

BENEFIT SCHEDULE

LOSS COVERED

Accidental Death

Dismemberment

- Loss or loss of use of two limbs
- Loss of sight of both eyes
- Loss or loss of use of one limb
- Loss of hearing of both ears
- Loss of speech

Sudden Cardiac Arrest

AMOUNT PAYABLE

100% of Sum Insured

100% of Sum Insured

100% of Sum Insured

50% of Sum Insured

50% of Sum Insured

50% of Sum Insured

100% of Sum Insured



- Benefits are payable in addition to any other plan.
- Benefits are payable for loss caused by exposure to the weather or in a conveyance that results in disappearance or sinking and the body is not found within 365 days of the accident. Benefits will be paid on the basis of presumption of death.
- Benefits may be taken in a single lump sum or in equal annual installments.
- Covers accidental bodily injury sustained while the Certificate is in force and which results in loss within 365 days of the date of the accident.
- War or acts of war and/or terrorism may be covered under this plan by applying for such and paying the additional premium.

- This certificate does not cover injury or death caused or contributed to by war, declared or undeclared, or acts of terrorism (unless such coverage is applied for and the appropriate additional premium has been paid), intentional self-inflicted injury or injury while committing a criminal or felonious act, alcoholism, drug addiction.



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.*