

Disclaimer



Insurance can be effective only after the underwriting department receives and reviews your application. The earliest effective date will be the next day after the review.

Underwriting department is open from Monday through Friday, 7 AM to 4 PM, Pacific Time, excluding holidays.

By submitting this paper application, you acknowledge and agree that:

- Back dated applications are not possible.
- Requested effective date is not always guaranteed.
- It does not matter when you send the application by postal mail, fax or scanned copy in email.
- It does not matter when the postal mail, fax or email was received by us, as the underwriting department can consider the effective date only according to when they review the application.
- If there is any dispute between you and the underwriting department about when the effective date should be, the decision of the underwriting department will be final.
- You hold Insubuy and the writing agent (if any) harmless and relieve us from any liability because of this.

If the above terms are not acceptable to you, please do not submit the application.

If you need to purchase the insurance urgently with a specific effective date, please call our office at (866) INSUBUY or the writing agent to confirm, before sending the application.



PETERSEN
INTERNATIONAL UNDERWRITERS
Producer #: _____

Or scan and email to info [at] insubuy.com
**APPLICATION FOR HIGH LIMIT
ACCIDENTAL DEATH INSURANCE**

Proposed Insured: First _____ Middle _____ Last _____

Personal Statistics: Date of Birth ____/____/____ Height _____ Weight _____ Gender Male Female

Contact Information: Email _____ Telephone (____)____-____ Fax (____)____-____

Residence Address: Number & Street _____

City _____ State _____ Zip Code _____

Employer: _____

Business Address: Number & Street _____

City _____ State _____ Zip Code _____

Annual Income: US\$ _____ Occupation _____

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

Period of Insurance: Requested Effective Date _____ Expiry Date _____

Beneficiary: _____ Relationship _____

Address: _____

Policy Owner (If not the insured): _____ Relationship _____

Address: _____

Benefits (Check one): 24 Hour

Coverage (Check one): Accidental Death (AD) or Accidental Death & Dismemberment (AD&D) or Accidental Death, Dismemberment & Accidental Permanent Total Disability (AD&D & APTD)

If "Yes" is answered for any of the following questions please provide full details in the space below.

1. Have you any physical defect or infirmity? Yes No
2. Is your sight or hearing defective? Yes No
3. Have you ever suffered from any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind? Yes No
4. Have you ever suffered from high blood pressure, a heart condition, rheumatic fever or diabetes? Yes No
5. Have you ever suffered from a "slipped disc" or other spinal disorder, a hernia or any rheumatic or arthritic condition? Yes No
6. Have you ever been declined or accepted on special terms for life, accident or illness insurance? Yes No
7. Do you intend to engage in hazardous sports or any other pastimes that expose you to extra personal injury? Yes No
8. Will you be travelling outside of the USA? Yes No
9. Will any of your air travel be on private or chartered aircraft? Yes No

Question #	Please provide detailed information for each question answered "Yes"

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.

Proposed Insured _____ Signature _____ Date _____

Policy Owner Signature (If other than the proposed Insured) _____ Date _____