

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.



PERSONAL/FAMILY APPLICATION

I. Applicant

First _____ Middle _____ Last _____
 Date of Birth ____/____/____ Citizenship _____
 Email _____ Telephone (____)____-____ Fax (____)____-____
 Number & Street _____
 City _____ State _____ Zip Code _____
 Annual Income US\$ _____ Value of Personal Assets: _____
 Business or Occupation: _____ Name of Company: _____
 Number & Street _____
 City _____ State _____ Zip Code _____

II. Is the Applicant also to be insured? Yes No Please list all other persons to be insured.

Name: _____ Date of Birth: _____ City of Residence: _____

III. List details of anticipated travel outside country of residence (please include names, dates, places of travel and reasons)

IV. Please answer the following pertaining to ALL proposed Insureds:

1. Has there ever been any prior kidnapping, extortion, or detention incident? Yes No
2. Has there ever been any threat or attempt at a kidnapping, extortion, or detention? Yes No
3. Are there any current threats or incidents regarding kidnapping, extortion, or detention? Yes No
4. Is there any existing coverage at this time, or within the past 12 months? Yes No
5. Are any of the proposed insureds likely kidnapping prospects because of business, outside interests, or other activities? Yes No

If yes to any of these, please provide details: _____

V. Please indicate the coverage you are seeking:

(Please note that the maximum benefit cannot exceed personal assets)

\$250,000 \$500,000 \$750,000 \$1,000,000 Other amount: \$ _____

I have read the above and declare that to the best of my knowledge and belief the statements are true and complete and that I have not knowingly withheld any information which may be material to Underwriters in their assessment and acceptance of the risk. Signing this form does not bind the Applicant nor the Underwriters to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy or certificate of insurance be issued.

Applicant Name _____ Signature _____ Date _____

Producer #: _____

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: