Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093 | Phone: (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

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 #: 25735

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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:

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Email: info@insubuy.com