Disclaimer

PETERSEN® INTERNATIONAL UNDERWRITERS

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.

INSUBUY, 4200 Mapleshade Ln, Suite 200, Plano, TX 75093 | Fax: (972) 767-4470: Phone: (866) INSUBUY
Or scan and email it to info [at] insubuy.com

PETERSEN
INTERNATIONAL UNDERWRITERS

Producer Number: 25735

SHORT TERM MEDICAL - FAMILY APPLICATION

This is a temporary medical insurance plan intended to cover eligible expenses from injuries or illnesses which occur within the USA.

Primary Applicant Name (Policy Owner)	**Date of Birth**	**Gender**	**Hazardous Sports**
	/ /	◯M ◯F	◯Yes ◯No

Additional Applicants

	/ /	◯M ◯F	◯Yes ◯No
	/ /	◯M ◯F	◯Yes ◯No
	/ /	◯M ◯F	◯Yes ◯No
	/ /	◯M ◯F	◯Yes ◯No
	/ /	◯M ◯F	◯Yes ◯No

☒ I hereby confirm that the individuals listed above are not part of an Employer Group.

Number & Street _____

City _____ State_____ Zip Code _____

Email _____ Telephone (_____)_____-_____

Requested Effective Date*: _____ Months of Coverage Requested: _____

Deductible: $_____

*Coverage dates & premiums will be calculated and issued in full month increments. Coverage cannot exceed 11 months. The earliest effective date is the day after the application is submitted.

Monthly Payment Authorization

Credit Card: ◯Visa ◯MasterCard ◯American Express

Monthly Premium: $_____

Credit Card #: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: __ __ / __ __

Declaration

I declare that the above statements are true and complete. I/we am/are in good health and ordinarily enjoy good health. 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 this is a temporary insurance policy designed to cover the insured person(s) for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product. The understand I am financially responsible for the expenses incurred until the claim has been determined to be an eligible expense.

I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Primary Applicant: _____ Signature: _____ Date: _____
Please Print

Guardian of Insured: _____ Signature: _____ Date: _____
(If Applicant is under age 18) Please Print