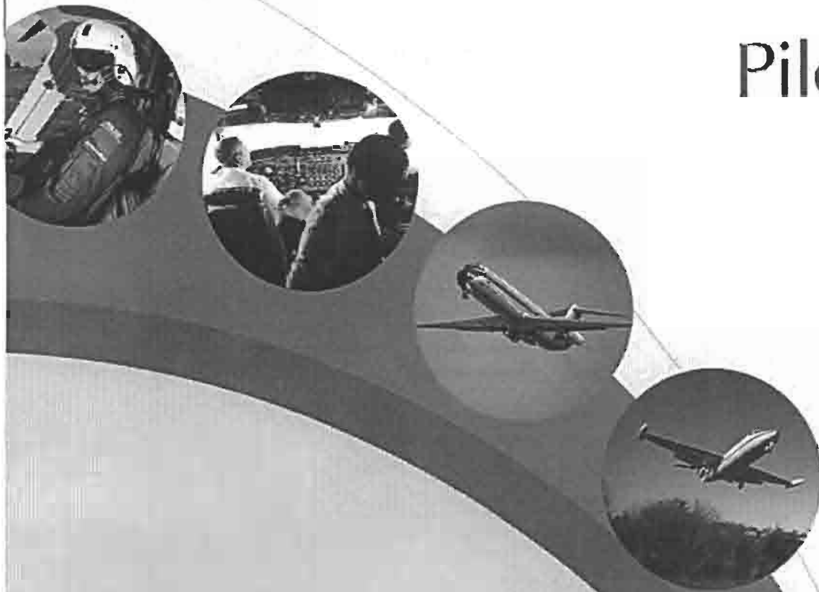

Pilot's Disability Insurance

"Temporary Loss of License"

Disability Insurance
for People Who Fly
For a Living

Commercial Pilots

Corporate Pilots

Cargo Pilots

Aerial Applicators

Agricultural Pilots

Firefighter Pilots

Air Show Pilots

Test Pilots

Air Ambulance Pilot

PETERSEN INTERNATIONAL UNDERWRITERS
Lloyd's Correspondents

***FAX COMPLETED APPLICATION TO:**
ATTN: DISABILITY INSURANCE
FAX: 314-963-9105

Proposal For: ______________________

Age: __________ **Date:** ______________

Presented By: Travers & Associates

Fax: 314-963-9105

Pilot's Disability Insurance Application

Part 1

Personal Information

1. **Name:** first ____________ middle ____________ last ____________

   Address: number & street ____________

   city ____________ state ____________ zip ____________

   Date of Birth: ____________ **Place of Birth:** ____________ **Height:** ____________ **Weight:** ____________

   Telephone: ____________ **Fax:** ____________ **E-mail:** ____________

   Flight Category: ☐ Air Show Pilot ☐ Test Pilot ☐ Commercial Airline Pilot ☐ Corporate Pilot ☐ Firefighter Pilot ☐ Agricultural Pilot ☐ Aerial Applicator ☐ Cargo Pilot

   Aircraft Category: ☐ Fixed Wing ☐ Helicopter

2. **Employer:** a) Flying Occupation ____________

   b) Non-Flying Occupation ____________

3. **Salary or Earned Income:** a) Flying Occupation: $ ____________ b) Non-Flying Occupation: $ ____________

4. **Insurance for which you are applying:** a) Monthly Benefit Amount: $ ____________ b) Elimination Period: ____ days c) Benefit Period: ____ months

Flying information

5. **Current Licenses:** ☐ Flight Instructor ☐ Commercial ☐ Instrument Flight Rating ☐ Airline Transport Rating ☐ Rotorcraft ☐ Multi-Engine

   a) Date of Last FAA Medical Exam ____________ b) Date of Last Biennial Flight review (BFR) ____________

Insurance Information

6. a) Are you entitled to benefits under any accident or sickness insurance arranged by you or your employer? (including Loss of License, permanent health or Aircrew Disability Insurances) ☐ No ☐ Yes

   If yes, please give details: ____________

   b) Are you covered under a state disability program? ☐ No ☐ Yes

7. Is this application for replacement of existing insurance? ☐ No ☐ Yes

   If yes, please give full details of any pervious policy (i.e. Sum Insured, Name of Insurer, etc.): ____________

   ____

8. **Have you ever:** a) engaged in hazardous sports or hobbies such as parachuting, auto or motorcycle racing? ☐ No ☐ Yes

   b) had your driver's license suspended or revoked during the past three years? ☐ No ☐ Yes

   If yes, please give details: ____________

   ____

IT IS UNDERSTOOD AND AGREED

1. That all answers to the above questions, to the best of my knowledge and belief, are complete and true.
2. That all answers to the above questions, together with the application, shall form the basis of the insurance of any coverage hereunder.
3. That in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on both sides of the application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
4. The insurance hereunder applied for shall take effect in the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.

____________ Date

X ____________ Signature of Proposed Insured

____________ Signature of Applicant-Purchaser if not Proposed Insured

Pilot's Disability Insurance Application

Part 2

If **Yes** on any answers, please give **DATES** and **FULL DETAILS**

9. Have you had investigated, diagnosed or been treated for:

a) any psychiatric or nervous disorder (including migraine), epilepsy or any other form of convulsions or any loss of consciousness? ☐ Yes ☐ No

b) any heart, blood pressure, circulatory or respiratory disorder? ☐ Yes ☐ No

c) any condition involving eyes, nose, throat, alimentary tract, or genito-urinary system? ☐ Yes ☐ No

d) any disorder of the blood or lymphatic systems? ☐ Yes ☐ No

e) any condition affecting the bones and / or joints (including spinal conditions)? ☐ Yes ☐ No

f) any disorders of the skin? ☐ Yes ☐ No

g) diabetes? ☐ Yes ☐ No

10. Have you ever been grounded or had your license invalidated for medical reasons? ☐ Yes ☐ No

11. Has any limitations ever been endorsed on your license? ☐ Yes ☐ No

12. After or during a medical examination:

a) Have you ever been required to take additional test? ☐ Yes ☐ No

b) Have you ever been referred to a specialist for an examination? ☐ Yes ☐ No

c) Have you ever had the issue or renewal of your medical certificate deferred? ☐ Yes ☐ No

d) Have you ever had to return for examination at less than the normal interval time? ☐ Yes ☐ No

e) Have you ever been ordered to take drugs or follow any specific diet? ☐ Yes ☐ No

13. Are you aware of any deterioration in your general health, hearing, eyesight or blood pressure? ☐ Yes ☐ No

14. Has any insurance company or underwriter:

a) declined or deferred an application from you? ☐ Yes ☐ No

b) charged or quoted more than standard rates? ☐ Yes ☐ No

c) cancelled or declined to renew your insurance? ☐ Yes ☐ No

15. Are you taking medication? ☐ Yes ☐ No

No.	Details

16. Please give the date of your last Electrocardiograph exam approved by the license issuing authority: ____________

IT IS UNDERSTOOD AND AGREED

1. That all answers to the above questions, to the best of my knowledge and belief, are complete and true.
2. That all answers to the above questions, together with the application, shall form the basis of the insurance of any coverage hereunder.
3. That in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on both sides of the application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
4. The insurance hereunder applied for shall take effect in the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.

____________ Date

X____________ Signature of Proposed Insured

____________ Signature of Applicant-Purchaser if not Proposed Insured

PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Boulevard, Suite 215, Valencia, California 91355
(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604
Website: http://www.piu.org E-Mail: piu@piu.org

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.

X____ ____________________
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.*

Petersen International Underwriters
Privacy Policy Statement

Petersen International Underwriters

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

Information We Collect

We collect non-public information about you from numerous sources including, but not limited to:

a) Information we receive from you on applications and other forms;
b) Information about your transactions with our affiliates, others or us;
c) Information we receive from consumer-reporting agencies; and
d) Financial and medical sources.

Information We Disclose

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

Right to access or correct your personal information

You have a right to request access to or correction of your personal information in our possession.

Confidentiality and Security

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

Contacting Us

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: piu@piu.org

Pilot's Disability Insurance

Specified Occupation

This is a Specified Occupation Plan. It will terminate automatically if you change from the occupation in which you where engaged at the time the plan was issued, unless an agreement has been obtained in writing from the underwriters and any additional premium required by the underwriters has been paid. The sole liability of the underwriters in the event of an occupation change shall be returned on a pro-rata basis any unearned premiums paid for the balance of the plan term.

Exclusions

No benefits will be paid due to Sickness or Injury caused by, contributed to by or related to the following and / or their treatments and / or complications thereof:

1. Suicide or intentional self-inflicted injury or poisoning;
2. War, declared or undeclared (Please note that Terrorism or Acts of Terrorism is defined differently than war and is covered under this certificate);
3. An act of Terrorism involving the use or release of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s);
4. While committing or attempting to commit a crime;
5. Taking of illegal drugs, or addiction or misuse of prescription or non-prescription drugs;
6. Alcohol abuse or addition, or being under the influence or alcohol, as defined by the vehicle code of the state or province in which the Accident has occurred;
7. Mental or Nervous disorders;
8. Pre-Existing Conditions;
9. Subjective Pain or other symptoms unless supported by objective medical findings;
10. Pregnancy and pregnancy-related conditions including but not limited to fertility, pre-natal care, childbirth, miscarriage, abortion or postpartum conditions.

This brochure along with all of our other products and applications are available to download from our website

FAX COMPLETED APPLICATION TO:

ATTN: DISABILITY INSURANCE

FAX: 314-963-9105

This is a brief description of the insurance provided by this plan.
The Certificate of Insurance is the complete description of coverage.