High Limit Accident Application

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 __________________________

Countries to be visiting outside the U.S. (if any): ____

Air Travel: Will aviation travel be on regularly scheduled airlines? If no, please provide details: ❑ Yes ❑ No: ____________________

Occupation: ________________________________ **Annual Income US$**______________________________

Period of Insurance: Effective Date _______________________ Expiry Date ______________________________

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

Policy Owner (If not the insured): ________________________________ Relationship ______________________________

Address: ____

Beneficiary: ________________________________ Relationship ______________________________

Address: ____

Benefits (Check one): ❑ 24 Hour or ❑ Common Carrier or ❑ Air Travel Only

Options: ❑ Acts of War & Terrorism

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

Please answer all the questions and provide dates and details in the area 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

Dates & Details to all "YES" answers to questions #1-7 ______________________

____

____

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 recision. 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______________

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:

Petersen
International Underwriters
23929 Valencia Boulevard • Second Floor • Valencia, CA 91355
800.345.8816 toll-free • 661-254-0604 fax
www.piu.org • piu@piu.org