



# LOSS OF LICENSE INSURANCE APPLICATION

Producer Name	Producer #
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## PERSONAL INFORMATION

First	Middle	Last	
Place of Birth	Date of Birth	Height	Weight
Residence Street Address			
City	State	Zip Code	
Telephone	Fax	Email	
Policy Owner		Loss Payee	
Employer			
Licensing Authority Required by Employer - (FAA, CAAC, TCCA)			
Flying Occupation		Non-Flying Occupation	
Annual Flying Income (USD)		Annual Non-Flying Income (USD)	

## PREMIUM & BENEFIT

<b>Bill To:</b> <input type="radio"/> Email <input type="radio"/> Residence <input type="radio"/> Employer <input type="radio"/> Other: _____ _____	<b>Premium Mode:</b> <input type="radio"/> Multi-Year Prepay <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly (CC/EFT)	<b>Monthly Benefit Amount (if applicable):</b> \$ _____ Elimination Period (days): <input type="radio"/> 30 <input type="radio"/> 60 <input type="radio"/> 90 <input type="radio"/> 180 <input type="radio"/> 365 Benefit Period (months): <input type="radio"/> 12 <input type="radio"/> 24 <input type="radio"/> 36 <input type="radio"/> 48 <input type="radio"/> 60 <b>Lump Sum Benefit Amount (if applicable):</b> \$ _____ Elimination Period (months): _____

## FLYING INFORMATION

<b>Flight Categories:</b> <input type="checkbox"/> Corporate Pilot <input type="checkbox"/> Commercial Pilot <input type="checkbox"/> Cargo Pilot <input type="checkbox"/> Firefighter Pilot <input type="checkbox"/> Aerial Applicator <input type="checkbox"/> Powerline Inspection <input type="checkbox"/> Test Pilot <input type="checkbox"/> Other: _____
<b>Aircraft Categories:</b> <input type="checkbox"/> Fixed Wing <input type="checkbox"/> Helicopter

## INSURANCE INFORMATION

1. Expiration date of current medical authority certificate: _____ Any Medical Restrictions: <input type="radio"/> Yes <input type="radio"/> No If "Yes" please provide details: _____
2. Have you ever received a licensing authority denial of a deferral of your medical application? <input type="radio"/> Yes <input type="radio"/> No If "Yes" please explain when & how your medical certificate was reinstated: _____
3. Date of last Licensing Authority Medical Exam: _____ Any Medical Restrictions: <input type="radio"/> Yes <input type="radio"/> No Details: _____
4. Date of last Flight Review: _____ Any License Restrictions: <input type="radio"/> Yes <input type="radio"/> No Details: _____
5. Are you covered under a state disability program? <input type="radio"/> Yes <input type="radio"/> No Details: _____
6. Is this application for replacment of existing insurance? <input type="radio"/> Yes <input type="radio"/> No Details: _____
7. Have you ever engaged in hazardous sports or hobbies? <input type="radio"/> Yes <input type="radio"/> No Details: _____
8. Have you ever had your drivers license suspended or revoked during the past three years? <input type="radio"/> Yes <input type="radio"/> No Details: _____
9. 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 insurance? <input type="radio"/> Yes <input type="radio"/> No Details: _____



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## MEDICAL INFORMATION

*If "Yes" is answered for any of the following, please attach full details separately.*

10. Have you had investigated, diagnosed, been treated for, any symptoms lasting longer than 1 month or recurring symptoms of :	
a. any psychiatric or nervous disorder (including migraines), epilepsy or any other form of convulsions or any loss of consciousness?	<input type="radio"/> Yes <input type="radio"/> No
b. any heart, blood pressure, circulatory or respiratory disorder?	<input type="radio"/> Yes <input type="radio"/> No
c. any condition involving the eyes, nose and/or throat?	<input type="radio"/> Yes <input type="radio"/> No
d. any condition involving the gastrointestinal tract or the genitourinary tract?	<input type="radio"/> Yes <input type="radio"/> No
e. any disorder of the blood or lymphatic system?	<input type="radio"/> Yes <input type="radio"/> No
f. any condition affecting the bones and/or joints (including spine)?	<input type="radio"/> Yes <input type="radio"/> No
g. any disorder of the skin?	<input type="radio"/> Yes <input type="radio"/> No
h. diabetes?	<input type="radio"/> Yes <input type="radio"/> No
i. any condition(s) not mentioned above?	<input type="radio"/> Yes <input type="radio"/> No
11. After or during a medical examination, have you ever:	
a. been required to take an additional test?	<input type="radio"/> Yes <input type="radio"/> No
b. been referred to a specialist for examination?	<input type="radio"/> Yes <input type="radio"/> No
c. had the issue or renewal of your medical certificate deferred?	<input type="radio"/> Yes <input type="radio"/> No
d. had to return for examination at less than the normal interval time?	<input type="radio"/> Yes <input type="radio"/> No
e. been ordered to take drugs or follow any specific diet?	<input type="radio"/> Yes <input type="radio"/> No
12. Has any insurance company or underwriter:	
a. declined or deferred an application you submitted?	<input type="radio"/> Yes <input type="radio"/> No
b. charged or quoted more than standard rates?	<input type="radio"/> Yes <input type="radio"/> No
c. cancelled or declined to renew your insurance?	<input type="radio"/> Yes <input type="radio"/> No
13. Are you aware of any deterioration in your health, hearing, eyesight or blood pressure?	<input type="radio"/> Yes <input type="radio"/> No
14. Have you ever been grounded or had your license invalidated for medical reasons?	<input type="radio"/> Yes <input type="radio"/> No
15. Have you ever had any limitations or endorsements on your license?	<input type="radio"/> Yes <input type="radio"/> No
16. Are you currently taking any medications?	<input type="radio"/> Yes <input type="radio"/> No
17. Date of your last electrocardiograph examination approved by the license issuing authority: _____	

18. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application?  Yes  No

### IT IS UNDERSTOOD AND AGREED

1. that all answers on this application, to the best of my knowledge and belief, are complete and true; 2. that all answers on this application shall form the basis of the issuance of any coverage hereunder; 3. that in the event of any fraud, misstatement, concealment or failure to disclose information in any answers on this application, whether intentional or inadvertent, any coverage issued based upon this application may become void, and no benefit shall be payable; 4. the insurance applied for hereunder shall take effect on 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 answers on this application between the date of application and the effective date of the certificate; 5. no agent or broker or medical examiner has authority to waive or change any answer on this application; 6. that this application shall be attached to and form part of any coverage which may be subsequently issued; 7. I have read, or had read to me, and understand each of the questions and statements on this entire application; 8. no one has prevented me from spending as much time as I felt was necessary to understand this application.

\_\_\_\_\_  
Signature of Applicant      Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Policy Owner (if not Applicant)      Date: \_\_\_\_\_

**Agent Info: VisitorsCoverage Inc., 2350 Mission College Blvd, Suite #1140, Santa Clara CA 95054  
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