



International Term Life Insurance Application

NO insurance is in force until this application has been accepted and approved by underwriters and the first premium has been paid. Before any question is answered, please read carefully the declaration at the end of this application form, which must be signed and dated. Please ensure that all questions are answered fully and correctly by the person to be insured. Any question left unanswered will delay the assessment of the application for insurance.

Personal Information

Proposed Insured: First _____ Middle _____ Last _____
 Date of Birth: ____ / ____ / ____ Sex: Male Female Height: _____ Weight: _____
 Citizenship: _____ Place of Birth: _____ Nationality: _____
 Marital Status: _____ Number of Dependents: _____
 SS# or Passport#: _____ Country Issued: _____
 E-mail: _____ Telephone (____) _____ - _____ Fax (____) _____ - _____
 Address: Number & Street _____
 City _____ State _____ Zip Code _____ Country _____
 Employer: Name _____ Number & Street _____
 City _____ State _____ Zip Code _____ Country _____

Requested Term: Years _____ Requested Sum Insured: \$ _____
 Beneficiary: _____ Relationship: _____
 Contingent Beneficiary: _____ Relationship: _____

Policy Owner: First _____ Middle _____ Last _____
(if other than the Insured)
 Address: Number & Street _____
 City _____ State _____ Zip Code _____ Country _____
 Insurable Interest: _____

Occupation Information

Occupation: _____ Annual Income From Occupation: _____
 Net Worth: _____ Any Other Income and Source: _____

Do your occupational duties involve any of the following: (if yes please provide details)

- | | |
|--|--|
| 1. Working at heights? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Working offshore? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Diving or fishing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Military involvement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Any aviation exposure other than on regularly scheduled airlines? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Mining or working underground? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. The use of special safety precautions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Any activity that might be considered hazardous? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Questions # _____
 Questions # _____
 Questions # _____

International Term Life Insurance Application - Page 2 of 3

Premium Frequency Requested: Annual Semi annual Quarterly Monthly

Requested Effective Date: _____

Reasons for this insurance: _____

Is replacement of any insurance involved with this transaction: Yes No If Yes please provide details _____

Do you have any other life insurance in force or intending to be put into force: Yes No

<u>Insurer</u>	<u>Approximate Date of Issue</u>	<u>Life Insurance Sum Insured</u>
_____	_____	_____
_____	_____	_____

Medical History

Primary Care Physician: Name _____

Date & Reason Last Seen: Address _____

Reason Seen _____ Date _____ Results _____

Have you ever suffered from or been diagnosed with:

- | | | | |
|-----------------------|--|---|--|
| 9. Cyst? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Prostate problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Gout? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Rheumatic fever? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Lump? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Bladder problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Stroke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High Blood Pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Any disorder of the blood? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Any Chest or Lung disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Sexually transmitted disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Epilepsy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. X-Ray, MRI or other special tests? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chest pain? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Any Stomach or Bowel complaints? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. HIV / AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Disorder of the brain or spinal cord? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Heart disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Anxiety, Depression, or other Mental or Nervous disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Any operation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Dizziness, convulsions, neurological disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Liver problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 22. Hepatitis B or C? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 23. Kidney problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____
Questions # _____

International Term Life Insurance Application - Page 3 of 3

- | | |
|---|--|
| 36. Has your weight changed within the last 12 months? | <input type="checkbox"/> None <input type="checkbox"/> Gain <input type="checkbox"/> Loss • Amount _____ |
| 37. Have you used any tobacco within the last 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 38. How much alcohol do you consume per week? | <input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-8 <input type="checkbox"/> 9-10 <input type="checkbox"/> 11+ |
| 39. Have you ever been medically advised to reduce your alcohol consumption? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 40. Have you ever used drugs on a recreational basis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 41. Have you consulted any doctor, hospital, or clinic within the last 5 years, other than for clearly minor conditions such as colds, flu, etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 42. Are you taking any medicine or drugs whether or not prescribed by a physician or receiving any treatments of any kind? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 43. Have any of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer or a nervous disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 44. Has any application for insurance on your life or health been declined, withdrawn by yourself or accepted with special terms? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 45. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as previously described? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 46. Have you or any business owned in whole or in part by you ever been in Bankruptcy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 47. Do you engage in any hazardous sports or pastimes such as a private aviation, motor sports, diving, skiing or boarding, etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 48. Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australia? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Additional Details: _____

Important Notes – Please note that your answers to the questions on this application form will be used to assess the ability for us to offer you insurance. All material facts must be disclosed since part or all of the benefit that this insurance is to provide might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of this application. If you are unsure whether a particular fact is material you should disclose it. **Insurance coverage will not start until we have accepted your application and the first premium has been paid.** If you have a birthday while your application is being underwritten, the terms may differ from those originally quoted. We may ask you to contact your doctor to speed up the completion of reports that we may have requested. Both Petersen International Underwriters and our Life Underwriters have Confidentiality Policies in place. If you require a copy of such please contact our office.

Declarations – It is understood and agreed that all the answers to the above questions, to the best of my knowledge and belief, are true and complete; that all answers to the above questions, together with this application shall form the basis of the issuance of any coverage hereunder; that in the event of any fraud, misstatement, concealment or failure to disclose information in response to any question on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void in part or in whole with benefits not being payable; and the insurance hereunder applied for shall take effect on the date set forth on the certificate of insurance, 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 the application and the effective date of the certificate.

I have read the application, Important Notes and Declarations.

Signature of life to be insured: _____ Date: _____

Name of the Policy Owner: _____
(if other than the Insured)

Signature of Policy Owner: _____ Date: _____
(if other than the Insured)

Relationship of Policy Owner to the Insured: _____