The Bridge Plan Application Form Page 1 of 2

To be eligible for the Bridge Plan coverage, you must not be eligible for Medicare. **If you have been a legal resident of the USA for 5 years you are eligible to purchase Medicare and you should not complete this application.** Benefits are subject to all terms, limitations and conditions outlined in your certificate. Please read your certificate carefully once you receive it.

Producer #:30748_____

Please Provide the Following Personal Information

Applicant's Name: First _____ Middle _____ Last_____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ❑Male ❑Female

Residence Address: _____

City _____ State _____ Zip Code _____

E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____

Citizenship: _____ Length of Time Residing in the USA: _____

Requested Start Date: _____ Date you expect to be eligible for Medicare?_____

Deductible Amount: ❑ 1,000 ❑ 1,500 ❑ 2,500 ❑ 5,000 ❑ 10,000

Coverage Type: ❑ Bridge Part A & B ❑ Bridge Part A Only ❑ Bridge Part B Only

Payment Mode: ❑ In Full (11 Month Term) ❑ Monthly (EFT/CC)

Medical Information

Primary care physician:
a. Name & address: _____
b. Date and reason last seen: _____
c. Results of last visit: _____

Last healthcare provider seen:
a. Name & address: _____
b. Date and reason last seen: _____
c. Results of last visit: _____

If "Yes" is answered for any of the following questions please provide full details in the space below. If there is not sufficient space, please attach your answers on a separate sheet.

1. Have you had any medical insurance in the past year? ❑ Yes ❑ No
2. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ❑ Yes ❑ No
3. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
4. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ❑ Yes ❑ No
5. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed? ❑ Yes ❑ No
6. Date of last colonoscopy:_____ Results:_____
7. If Female: Date of last pap testing:_____ Results:_____
8. If Female: Date of last mammogram:_____ Results:_____

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

Please continue the application on the following page.

The Bridge Plan Application Form Page 2 of 2

For any questions that you answer "YES," please provide details of the medical condition including treatment, dates, diagnosis, prognosis, and present course of treatment in the area provided below or if additional space is needed please use a separate sheet and submit the it along with the application. Please attach these responses to this application. Underwriters may request additional medical information.

9. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?

a.	Eyes	❑ Yes ❑ No	aa.	Gall bladder	❑ Yes ❑ No
b.	Ears	❑ Yes ❑ No	ab.	Convulsions	❑ Yes ❑ No
c.	Nose	❑ Yes ❑ No	ac.	Concussions	❑ Yes ❑ No
d.	Cyst	❑ Yes ❑ No	ad.	Blood vessels	❑ Yes ❑ No
e.	Gout	❑ Yes ❑ No	ae.	Lymph nodes	❑ Yes ❑ No
f.	Knees	❑ Yes ❑ No	af.	Intestinal tract	❑ Yes ❑ No
g.	Back/spine/neck	❑ Yes ❑ No	ag.	Urinary system	❑ Yes ❑ No
h.	Skin	❑ Yes ❑ No	ah.	Arthritis/joints/rheumatism	❑ Yes ❑ No
i.	Liver	❑ Yes ❑ No	ai.	Nervous system	❑ Yes ❑ No
j.	Heart	❑ Yes ❑ No	aj.	Growth/tumor/cancer	❑ Yes ❑ No
k.	Blood	❑ Yes ❑ No	ak.	Unconsciousness	❑ Yes ❑ No
l.	Bones	❑ Yes ❑ No	al.	Circulatory system	❑ Yes ❑ No
m.	Throat	❑ Yes ❑ No	am.	Fainting/dizziness	❑ Yes ❑ No
n.	Hernia	❑ Yes ❑ No	an.	Paralysis/weakness	❑ Yes ❑ No
o.	Fatigue/Tiredness	❑ Yes ❑ No	ao.	High blood pressure	❑ Yes ❑ No
p.	Bladder	❑ Yes ❑ No	ap.	Disorder of the brain/Alzheimer's	❑ Yes ❑ No
q.	Muscles	❑ Yes ❑ No	aq.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
r.	Kidneys	❑ Yes ❑ No	ar.	Lungs	❑ Yes ❑ No
s.	Glands	❑ Yes ❑ No	as.	Asthma	❑ Yes ❑ No
t.	Thyroid	❑ Yes ❑ No	at.	Allergies	❑ Yes ❑ No
u.	Pancreas	❑ Yes ❑ No	au.	Tuberculosis	❑ Yes ❑ No
v.	Diabetes	❑ Yes ❑ No	av.	Respiratory system	❑ Yes ❑ No
w.	Chest pain	❑ Yes ❑ No	aw.	Reproductive system	❑ Yes ❑ No
x.	Headaches	❑ Yes ❑ No	ax.	Digestive system/stomach	❑ Yes ❑ No
y.	HIV/AIDS	❑ Yes ❑ No			
z.	Sleep apnea	❑ Yes ❑ No			

10. Are you currently taking any medication? ❑ Yes ❑ No
11. Has your weight changed in the past year? ❑ Yes ❑ No
12. Have you ever undergone a surgical operation? ❑ Yes ❑ No
13. Have you taken any other medicines in the past 12 months? ❑ Yes ❑ No
14. Have you any reason to believe that a surgical operation may be necessary in the future? ❑ Yes ❑ No
15. Have you ever suffered from any other conditions or injuries for which medical advice was sought? ❑ Yes ❑ No
16. Other than the medical conditions noted above, I am in good health. ❑ Yes ❑ No
17. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

DECLARATION

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 health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctors to give 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 rescission.
I understand that pre-existing conditions are not covered until I have been treatment free for 24 months after inception.

Proposed Insured_____ Signature _____ Date_____
Please Print

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

Producer # 30748

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured ("Applicant") _____Date of Birth_____

I 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, 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.

_____ _____
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.