

TheInsuranceNet.com

Instructions for applying for disability insurance

- 1) Print out application.**
- 2) Fill out application completely.**
- 3) Send application to our office for rate computation and underwriting.**
- 4) Mail to...**

**TheInsuranceNet.com
5965 Sandy Ridge
Elkridge, MD 21075**

- 5) Call with questions 410-796-7497 or toll free 877-634-1256.**

THE EXECUTIVE 400 PLAN

Disability Insurance



FOR

Personal Estate Plans

*Income Replacement • Excess Disability
High Limit Disability*

Business Estate Plans

*Salary Continuation • Buy-Sell Agreements
Business Overhead Expense • Key Person
Contract Agreement
Bank Loan Indemnification*



PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondents

23929 Valencia Boulevard Suite 215 Valencia California 91355-2186
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604

E-Mail: piu@piu.org Website: www.piu.org

PROPOSAL FOR: _____

AGE: _____ DATE: _____

OCCUPATION: _____

PRESENTED BY: _____

THE EXECUTIVE 400 PLAN

MONTHLY DISABILITY BENEFITS

Proposed Use of This Insurance:

- Personal Disability Buy-Sell Salary Continuation Key Person
 Overhead Expenses Contract Guarantee Loan Indemnification

Monthly Benefits are payable while Totally Disabled or Residually Disabled, if applicable, beginning the first day following the Elimination Period and for as long as the Benefit Period **for each disability**.

	BENEFIT SCHEDULE	ANNUAL PREMIUM
MONTHLY BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Days	
BENEFIT PERIOD	_____ Months	
MAXIMUM BENEFIT EACH CLAIM	\$ _____	
OPTIONAL RESIDUAL DISABILITY RIDER		\$ _____
OPTIONAL COLA RIDER (CPI) 10%		\$ _____
TOTAL ANNUAL PREMIUM		\$ _____
TERM OF INSURANCE _____ YEARS		

UNDERWRITING REQUIREMENTS: Application Medical Exam Blood & Urine EKG _____

FINANCIAL INFORMATION: Confidential Financial Statement Tax Returns _____

SUPPLEMENTAL QUESTIONNAIRE: BOE Key Person Buyout _____

SPECIAL FEATURES

- **TOTAL DISABILITY MONTHLY BENEFITS** are payable when, due to **sickness or injury**, you cannot perform the **substantial and material duties of your regular occupation** and you are under the regular care of a legally qualified physician.
- **PRESUMPTIVE DISABILITY** benefits will be paid for the maximum benefit period **even if you are able to return to your own or any other occupation**. Benefits will be paid should you **lose the use of** both hands, both feet, one hand and one foot, the sight in both eyes, hearing in both ears, or the ability to speak. The medical care requirements and the elimination period will be automatically waived.
- **RECURRENT DISABILITIES** resulting from the same cause or causes are considered a **new claim** with a **new benefit period** if you have returned to your regular occupation, full-time, for six months or longer.
- **TRANSPLANT BENEFIT** means that Total Disability benefits will be paid for disability following surgery **if you donate an organ from your body** to another person. Benefits will be paid as a sickness benefit. This benefit is applicable after the certificate has been in force for six months or longer.

- **OPTIONAL RESIDUAL DISABILITY RIDER BENEFITS** are payable when you are **engaged in your regular occupation, or another occupation, and you experience reduced income of 20% or more, due to a disability**. The benefit amounts will be calculated by multiplying the Monthly Benefit Amount provided by this Certificate by the percentage of reduced income compared to the average monthly earned income received during the twelve month period preceding the onset date of the disability.
- **OPTIONAL COST OF LIVING ADJUSTMENT (COLA)** will automatically increase the monthly benefit amount based upon the Consumer Price Index (CPI), but not to exceed 10% per year.

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

THE EXECUTIVE 400 PLAN

LUMP SUM DISABILITY BENEFITS

Proposed Use of This Insurance:

- Personal Disability Buy-Sell Salary Continuation
 Key Person Contract Guarantee Loan Indemnification

The **Principal Lump Sum Benefit** is payable at the expiry of the specified elimination period.

	BENEFIT SCHEDULE	ANNUAL PREMIUM
LUMP SUM BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Months	
TERM OF INSURANCE	_____ Year(s)	

UNDERWRITING REQUIREMENTS: Application Medical Exam Blood & Urine EKG _____

FINANCIAL INFORMATION: Confidential Financial Statement Tax Returns _____

SUPPLEMENTAL QUESTIONNAIRE: BOE Key Person Buyout _____

SPECIAL FEATURES

- **This is not an aggregate policy!** This benefit is payable, **in addition to and not reduced by**, any other disability benefits provided by this or any other plan.
- The **Principle Sum Benefit** will be paid to you or to a designated loss payee, trust or annuity carrier. You may elect to receive the Benefit in any one of the following ways:
 1. Single payment
 2. Monthly benefits for a certain period of time or to a prescribed age.
 3. Monthly benefits for life.
 4. Interest only for life with Principal Sum paid to beneficiaries at the time of your death.
- **Simple Arbitration** is utilized should your physician and our physician not be able to agree that you are permanently totally disabled. Your physician and our physician shall name a third physician to make a decision on the matter which shall be final and binding.
- Disability must result from an injury or sickness which is first diagnosed or incurred and which results in a loss beginning while the certificate is in force.
- You must have been totally disabled for the elimination period and at the end of such period you are determined by competent medical authority to be unable to resume the material duties of your regular occupation and that you have suffered a career-ending disability.

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

THE EXECUTIVE 400 PLAN

DEFINITIONS

Sickness means disease or illness which is first diagnosed and results in a disability beginning while the Certificate is in force.

Injury means accidental bodily injury sustained and which results in a disability beginning while the Certificate is in force.

SPECIFIED OCCUPATIONS

This is a Specified Occupation Plan. It will terminate automatically if you change from the occupation in which you were engaged in 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 to return on a pro-rata basis any unearned premiums paid for the balance of the plan term.

TERM OF INSURANCE

The Certificate of Insurance is issued for periods of insurance ranging from one (1) to five (5) years in duration. It is contemplated that the plans will be renewed, however, the underwriters reserve the right to refuse to renew the Certificate or to change the premium rates on renewal of the Certificate. A statement of good health may be required by the underwriters for consideration of renewal. Non-renewal by the Insurer will be without prejudice to any claim in connection with a loss commencing while this plan is in force.

GRACE PERIOD

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the plan shall continue in force.

This plan does not cover sickness, injury or death caused or contributed to by war, declared or undeclared, acts of terrorism, suicide, self-inflicted injury or poisoning, the taking of illegal or non-prescribed drugs, drunkenness or alcoholism, mental or nervous disorders. It does not cover subjective pain unless supported by objective medical findings or injuries or sickness sustained while committing or attempting to commit a crime.

**This brochure along with all of our other products and application
are available to download from our website: www.piu.org**

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

APPLICATION FOR DISABILITY INSURANCE

to: **PETERSEN INTERNATIONAL UNDERWRITERS**

23929 Valencia Blvd., Suite 215, Valencia, California 91355 • (800) 345-8816

Underwritten by Certain Underwriters at Lloyd's

PART I

1. Full Name of Proposed Insured:	2a. Sex:	b. Age:
3a. Occupation :	c. Date of Birth:	
b. Material duties which account for the majority of your income:	d. Place of Birth:	
c. Substantial duties which account for most of your work time:	e. Soc. Sec. No.	

4a. Name & Address of Employer:	b. Length of service:
5. Residence Address:	c. Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No

6. Send Notices to: Business Residence Other Phone Number: _____

7. Your former occupation, if changed within 2 years: _____
If yes is answered for any of the questions 8 through 11, give details in remarks (No. 21)

8. Is foreign travel or residence contemplated? Yes No

9. Have you ever engaged in hazardous sports or hobbies such as parachuting, auto or motorcycle racing? Yes No

10. Have you had your driver's license suspended or revoked during the past three years? Yes No

11. Have you ever had life, health or accident insurance declined, postponed, cancelled, rated or modified, or renewal or reinstatement of such refused? Yes No

12a. List below all life, medical and disability insurance for which you are presently applying, have in force, or are applying to reinstate. Include all individual, group, mortgage and credit plans. (If none, please indicate.)

Insurer	Date of Issue	Life Insurance Face Amount	Disability Mo. Benefit	Benefit Period	Lump Sum	Personal or Business	Premium Payor

12b. Does your employer provide any disability benefits or salary continuation benefits? If yes, provide details. Yes No

13. Are you covered under a state disability program? (If yes, give full details in No. 12) Yes No

14. BENEFITS APPLIED FOR:

Section I
 Personal Disability Overhead Expense Key Person
 Bank Loan Indemnification Buy/Sell _____
Accident and Sickness Temporary Total Disability
Monthly Benefit Requested \$ _____
Elimination Period Requested _____ days
Benefit Period Requested _____ months
 Optional Residual Optional COLA

Section II
 Personal Disability Key Person
 Bank Loan Indemnification Buy/Sell _____
Accident and Sickness Permanent Total Disability
Elimination Period Requested _____ days
Principal Sum Requested \$ _____

Section III
Accidental Death and Dismemberment
Principal Sum Requested \$ _____

15. Are you terminating any existing policies in order to qualify for the policy (or policies) now applied for? (If yes, give details with termination dates in Remarks, No. 22) Yes No

16. Who will pay premium on policy? _____

17. Beneficiary: _____
Relationship: _____

18. Policy Owner (if other than insured): _____

19. Loss Payee (if other than insured): _____

20. Loss Payee's IRS Account Number: _____

21. Remarks: _____

22. a. What were your earnings from your occupation or profession last year: (Gross income less business expenses, but before taxes) \$ _____
b. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (circle items) \$ _____
c. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? Is this included in 22a? Yes No \$ _____

Documentation of figures shown in 22 (a) through (c) may be needed to complete underwriting. Such documentation will be copies of individual or corporate income tax returns, or W-2 forms.

IT IS UNDERSTOOD AND AGREED

- that all answers to the above questions, to the best of my knowledge and belief, are complete and true.
- 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 both sides of this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
- the insurance hereunder applied for 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 questions on this application between the date of application and the effective date of the certificate.
- Binding Arbitration - Waiver of Right to Trial by Jury: I understand and agree that any dispute concerning this insurance must be submitted to binding arbitration if the amount in dispute exceeds the jurisdictional limits of small claims court and is not resolved with a formal review by Underwriters. I understand and agree that this is a waiver of my and Underwriters rights to a trial by jury.**

Signature of Proposed Insured

Date: _____

Signature of Applicant-Purchaser if not Proposed Insured.
If a corporation or other firm, show full name of firm.

APPLICATION FOR DISABILITY INSURANCE

to: PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Blvd., Suite 215, Valencia, California 91355 • (800) 345-8816

Underwritten by Certain Underwriters at Lloyd's

PART II

23. a. Name and address of your personal physician (if none, please indicate): _____
 b. Date and reason you last consulted a physician, psychotherapist, psychologist or other healthcare provider: _____
 c. What treatment was given or medication prescribed?: _____
 d. If the consultation was for a checkup, did symptoms, disease, illness or injury prompt the checkup? (If yes, explain in No. 28) Yes No

24. a. Your height _____ ft. _____ in.
 Your weight _____ lbs.
 b. How much has your weight changed in the last year?
 None Gain _____ lbs. Loss _____ lbs.
 c. Marital status: _____

25. Have you, to the best of your knowledge, ever been treated for or had any indication of any of the following?
- | | | | | | | |
|---|--------------------------|--------------------------|--|---|--------------------------|--------------------------|
| | YES | NO | | | YES | NO |
| a. Disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | | g. Rheumatism, gout, arthritis or any deformity or disorder of the spine, muscles, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Headaches, fainting, unconsciousness, convulsions, paralysis, or any disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> | | h. Diabetes; disorder of the thyroid, pancreas or lymph nodes; or any disorder of the glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tuberculosis, asthma, or any disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> | | i. Cancer, tumor, or cyst or growth? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, high blood pressure, heart murmur, or any disorder of the heart, spleen, blood, blood vessels or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> | | j. Any disorder of the skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Disorder of the digestive system including stomach, intestines or bowel, liver, rectum, appendix, or gall bladder? | <input type="checkbox"/> | <input type="checkbox"/> | | k. Hernia, or any disorder of the reproductive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Disorder of genito-urinary system including kidneys, bladder or any other urinary disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | l. Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | m. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told you had AIDS or ARC (AIDS related complex)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | n. Any physical disorder, injury, or abnormality within the last 5 years, not disclosed in the answers above (No. 25 a-m) | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | | | | |
|---|--------------------------|--------------------------|--|---|--------------------------|--------------------------|
| | YES | NO | | | YES | NO |
| 26. a. Within the last 5 years have you ever had an injury or sickness which was the basis for an insurance claim? | <input type="checkbox"/> | <input type="checkbox"/> | | f. Have you ever received treatment or joined an organization for alcoholism or drug dependence? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Within the last 5 years have you ever had or been advised to have a surgical operation or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> | | g. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other similar drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests? | <input type="checkbox"/> | <input type="checkbox"/> | | h. Have you ever used tobacco at any time within the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Are you now taking medication? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| e. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

27. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described above? (If "No," explain fully in Remarks No. 29.) Yes No

28. Give complete details below to any questions above which are answered "yes."

Question Number	Details of Conditions or Treatment	Date and Duration	Details and Degree of Recovery	Doctors and Hospitals with addresses

29. REMARKS: _____

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 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 response to any question on both sides of this 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 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 questions on this application between the date of application and the effective date of the certificate.
5. **Binding Arbitration - Waiver of Right to Trial by Jury: I understand and agree that any dispute concerning this insurance must be submitted to binding arbitration if the amount in dispute exceeds the jurisdictional limits of small claims court and is not resolved with a formal review by Underwriters. I understand and agree that this is a waiver of my and Underwriters rights to a trial by jury.**

Date: _____

Signature of Proposed Insured

Signature of Applicant-Purchaser if not Proposed Insured.
If a corporation or other firm, show full name of firm.



DISABILITY DIVISION

Confidential Financial Statement

Proposed Insured: FIRST _____ MIDDLE _____ LAST _____

The following financial disclosure is made for the purpose of establishing insurability in connection with a pending disability application on myself. This is furnished as a true and accurate statement of my financial condition as of

_____, 20_____

I. ANNUAL INCOME from occupation or profession (Show adjusted gross income before taxes and after business expenses. List commission and bonus income separately.)				\$ _____	\$ _____	\$ _____
Commission Income				\$ _____	\$ _____	\$ _____
Bonuses				\$ _____	\$ _____	\$ _____
Pension & Profit Sharing Contributions (Applicable to Professional and Small Close Corporations only. Not to be included above.)				\$ _____	\$ _____	\$ _____
II. OTHER INCOME						
Dividends and Interest				\$ _____	\$ _____	\$ _____
Net Real Estate Income before Depreciation (Gross income less expenses and payments)				\$ _____	\$ _____	\$ _____
Other (Please specify)				\$ _____	\$ _____	\$ _____
_____				\$ _____	\$ _____	\$ _____
_____				\$ _____	\$ _____	\$ _____
III. TOTAL CURRENT NET WORTH (Please itemize below)				\$ _____		
Cash, Savings, Stocks, Bonds				\$ _____		
Personal Property (e.g. furnishings, jewelry, car, boat, etc.)				\$ _____		
Personal Residence (fair market value less mortgages, loans)				\$ _____		
Other Real Estate (fair market value less mortgages, loans)				\$ _____		
Business Interest (show fair market value less mortgages, loans)				\$ _____		
Other (Please specify)				\$ _____		
_____				\$ _____		
_____				\$ _____		
IV. ADDITIONAL CLARIFYING INFORMATION						

I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

_____ Date

_____ Signature of Proposed Insured

PETERSEN INTERNATIONAL UNDERWRITERS
Lloyd's Correspondents

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PETERSEN INTERNATIONAL UNDERWRITERS

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AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give to Petersen International Underwriters, Inc., any and all such information.

I UNDERSTAND the purpose of this Authorization is to allow Petersen International Underwriters, Inc., to determine eligibility for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by Petersen International Underwriters, Inc., to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organization performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request receive a copy of this Authorization.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and a half years from the date shown below.

Signed this _____ day of _____ 20 _____

Signature of Proposed Insured