



# PHYSICIANS & SURGEONS HIGH LIMIT

## *Disability Insurance*



### ***Personal Estate Plans***

*Income Replacement  
Supplemental Disability  
High Limit Disability*

### ***Business Estate Plans***

*Buy/Sell Agreements  
Business Overhead Expense  
Key Person  
Contract Guarantee  
Bank Loan Indemnification*



## **PETERSEN INTERNATIONAL UNDERWRITERS**

*Lloyd's Correspondents*

23929 Valencia Boulevard Suite 215 Valencia California 91355  
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604  
E-Mail: [piu@piu.org](mailto:piu@piu.org) Website: [www.piu.org](http://www.piu.org)

PROPOSAL FOR: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRESENTED BY: \_\_\_\_\_



# MONTHLY DISABILITY BENEFITS

## Proposed Use of This Insurance:

- Personal Disability     Buy-Sell     Buy-In     Buy-Out     Overhead Expenses  
 Key Person     Contract Guarantee     Bank Loan Indemnification

**Monthly Disability Benefits** will be paid while you are disabled beginning the first day following the Elimination Period and for as long as disabled, but not longer than the Benefit Period.

	BENEFIT	ANNUAL PREMIUM
MONTHLY BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Days	
BENEFIT PERIOD	_____ Months	
MAXIMUM BENEFIT, EACH CLAIM	\$ _____	
<b>OPTIONAL BENEFITS:</b>		
RESIDUAL DISABILITY RIDER		\$ _____
COST OF LIVING ADJUSTMENT RIDER		\$ _____
<b>TOTAL ANNUAL PREMIUM</b>		\$ _____
TERM OF INSURANCE	_____ Years	

**UNDERWRITING REQUIREMENTS:**     Application     Medical Exam     Blood & Urine     EKG

**FINANCIAL INFORMATION:**     Confidential Financial Statement     Tax Returns     \_\_\_\_\_

## SPECIAL FEATURES

- **TOTAL DISABILITY:** Benefits will be paid to you when due to **sickness or injury you no longer have the ability to perform in any professional capacity within the medical profession.**
- **PRESUMPTIVE DISABILITY:** Benefits will be paid for the maximum Benefit Period **even if you are able to return to any other occupation** 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:** Is a Total Disability benefits that will be paid for disability following surgery **if you donate an organ from your body** to another person. This benefit is applicable after the policy has been in force for six months or longer.
  
- **RESIDUAL DISABILITY:** Benefits will be paid when you are engaged in your occupation and **your income is reduced** due to a disability by 20% or more. The benefit will be calculated by multiplying the monthly benefit by the percentage of reduced income compared to the average income for the preceding twelve months at the time of disability.
- **OPTIONAL COST OF LIVING ADJUSTMENT (COLA)** will annually **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.*



# LUMP SUM DISABILITY BENEFIT

## Proposed Use of This Insurance:

- Personal Disability     Buy-Sell     Buy-In     Buy-Out  
 Key Person     Contract Guarantee     Bank Loan Indemnification

**The Lump Sum Disability Benefit** is payable as a result of a covered injury or sickness resulting in you becoming permanently and totally unable to perform in any professional capacity within the medical profession.

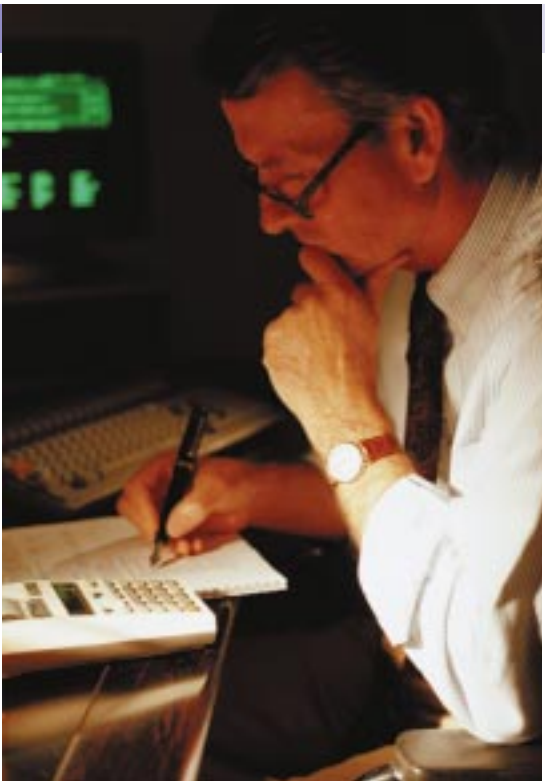
	BENEFIT	ANNUAL PREMIUM
BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Months	
TERM OF INSURANCE	_____ Year(s)	

**UNDERWRITING REQUIREMENTS:**     Application     Medical Exam     Blood & Urine     EKG

**FINANCIAL INFORMATION:**     Confidential Financial Statement     Tax Returns     \_\_\_\_\_

## BENEFIT PROVISIONS

- The **Lump Sum Disability Benefit** may stand alone or may be designed to follow the end of the benefit period of the Monthly Disability Benefits.
- The **Lump Sum Benefit** may be taken in a **single lump sum**, in **multiple sum amounts** or **deposited to an annuity plan** to provide long-term or lifetime cash-flow on a monthly basis.
- 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 any professional duties within the medical profession and that you have suffered a career-ending disability.



- We reserve the right to have you examined by a physician of our choice. 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.

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

# GENERAL INFORMATION



## DEFINITIONS

**TERM OF INSURANCE** is the time period during which the terms of the certificate or the rates charged cannot be changed by the Underwriters. The Term of Insurance is typically twelve to thirty-six months. On the renewal date following a Term of Insurance the underwriters reserve the right to refuse renewal or to offer renewal with different terms or rates.

A **GRACE PERIOD** of thirty-one 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 IS A MEDICAL OCCUPATION** certificate. The plan will automatically terminate if you change your occupation to something outside the medical profession after the certificate is issued, unless you get written acceptance from underwriters to agree to cover you in your new occupation. 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 which had been paid.

**PHYSICIANS, COMPETENT MEDICAL AUTHORITY** means an individual who is qualified to perform or prescribe surgical or manipulative treatment. A physician must be recognized (licensed or chartered) by the State or County in which he or she is practicing, cannot be a relative, must practice within the scope of his or her license. Treatment of a sickness or accident must be within the knowledge or expertise of the Physician.

**SICKNESS** means any sickness, illness or disease which is diagnosed or treated by a physician while this certificate is in force and is not excluded from coverage by name or specific description.

**INJURY** means accidental bodily injury sustained while the certificate is in force and results in a disability beginning while the certificate is in force.

## EXCLUSIONS



This policy does not cover any loss resulting from pregnancy, maternity, suicide or attempted suicide, intentionally self-inflicted injuries while sane or insane, alcoholism, drug addiction, mental or nervous disorders, subjective pain unless supported by objective medical findings as to the cause of the pain, the commission or attempted commission of a criminal or felonious act or serving in the military service of any country except for service in the military reserve of the United States.

War, declared or undeclared, riot or civil insurrection, or acts of terrorism are not covered unless an additional premium has been paid to provide such coverage and the underwriters have accepted this extended risk.

*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: <b>Section I</b> <input type="checkbox"/> Personal Disability <input type="checkbox"/> Overhead Expense <input type="checkbox"/> Key Person <input type="checkbox"/> Bank Loan Indemnification <input type="checkbox"/> Buy/Sell <input type="checkbox"/> _____ <i>Accident and Sickness Temporary Total Disability</i> Monthly Benefit Requested \$ _____ Elimination Period Requested _____ days Benefit Period Requested _____ months <input type="checkbox"/> Optional Residual <input type="checkbox"/> Optional COLA <b>Section II</b> <input type="checkbox"/> Personal Disability <input type="checkbox"/> Key Person <input type="checkbox"/> Bank Loan Indemnification <input type="checkbox"/> Buy/Sell <input type="checkbox"/> _____ <i>Accident and Sickness Permanent Total Disability</i> Elimination Period Requested _____ days Principal Sum Requested \$ _____ <b>Section III</b> <i>Accidental Death and Dismemberment</i> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
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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**

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*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.**

\_\_\_\_\_  
Signature of Proposed Insured

Date: \_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_

<b>I. ANNUAL INCOME</b> 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.)				\$ _____	\$ _____	\$ _____
<b>II. OTHER INCOME</b>						
Dividends and Interest				\$ _____	\$ _____	\$ _____
Net Real Estate Income before Depreciation (Gross income less expenses and payments)				\$ _____	\$ _____	\$ _____
Other (Please specify)				\$ _____	\$ _____	\$ _____
_____				\$ _____	\$ _____	\$ _____
_____				\$ _____	\$ _____	\$ _____
<b>III. TOTAL CURRENT NET WORTH</b> (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)				\$ _____		
_____				\$ _____		
_____				\$ _____		
<b>IV. ADDITIONAL CLARIFYING INFORMATION</b>						

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

23929 Valencia Boulevard, Suite 215, Valencia, California 91355

(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604

## 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 \_\_\_\_\_

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*Signature of Proposed Insured*