

TheInsuranceNet.com

Instructions for applying for health insurance

- 1) Print out application.**
- 2) Fill out application completely.**
- 3) If paying by credit card, fax back to 410-796-7456 (24 hr fax)* or call our office to enroll by phone.**
- 4) If paying by check or money order, make it payable to “Petersen International” and mail to....**

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

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

THE WORLDWIDE MAJOR MEDICAL PLAN

An International Major Medical Series Product



WORLDWIDE COVERAGE FOR

*People who work or reside
outside the United States
permanently or for
extended periods of time*

Now
up to
\$5,000,000
Maximum
Benefit!



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

**Visit our website to download
our brochures and applications,
or to apply online.
www.piu.org**



THE WORLDWIDE MAJOR MEDICAL PLAN APPLICATION

To: **PETERSEN INTERNATIONAL UNDERWRITERS**

Lloyd's Correspondents

5965 Sandy Ridge • Elkridge, MD 21075 • Tel (877) 634-1256 • fax 410-796-7456

To be eligible for this coverage, you must reside outside the United States for more than 5 months per year. Benefits may be assignable. Benefits are subject to all terms, limitations and conditions outlined in your certificate. **Please read your certificate carefully once you receive it.**

Plan Type:	<input type="checkbox"/> Excluding USA	<input type="checkbox"/> Including USA		
	Proposed Insured:			
	FIRST	MIDDLE	LAST	
	Non-U.S.A. Address:			
	_____ (____) _____			
	DAYTIME PHONE NUMBER			
	U.S.A. Address:			
	STREET AND NUMBER			
	CITY	STATE	ZIP	
	_____ (____) _____			
DAYTIME PHONE NUMBER				
Personal Information:				
Citizen of what country:	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
Occupation:		Details of Duties: _____		
Medical Attendant:		_____		
Address:		_____		
Time outside U.S.A.:	(per year, please)	Deductible Requested: _____		
Effective Date:	_____ (Earliest effective date is 24 hours after Underwriting approval)			
Optional Benefit:	<input type="checkbox"/> Hazardous Sports: Specify Sport: _____		<input type="checkbox"/> All-cause Deductible	

Questions 1-22 must be answered to receive consideration for coverage. For any questions that you answer "YES," please provide details of the medical condition including treatment, dates, name address and phone number of attending physician, diagnosis, prognosis, and present course of treatment on a separate sheet. **Please attach these responses to this application.** The Underwriters may request additional medical information.

- During the past 5 years, have you been diagnosed with any medical condition, received treatment (including medications or consultations), or been hospitalized for any medical, mental or nervous conditions? YES NO
- Are you currently disabled or unable to perform normal activities? YES NO
- Have you ever been declined or accepted on a modified term basis for life, disability or medical insurance? YES NO
- Have you ever received treatment or joined an organization for alcoholism or drug dependency? YES NO
- Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), Lymphadenopathy Syndrome, or any Immune System Disorder? YES NO

Have you EVER been treated for, or have been told that, or have reason to believe that, you have any diseases, conditions, medical problems, disorders, sicknesses, or problems relating to any of the following:

- | | |
|--|---|
| 6) Heart? <input type="checkbox"/> YES <input type="checkbox"/> NO | 16) Bone, skeleton, muscles, joints or skin? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7) Blood Vessels or circulatory system? <input type="checkbox"/> YES <input type="checkbox"/> NO | 17) Allergy? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8) Blood Pressure? <input type="checkbox"/> YES <input type="checkbox"/> NO | 18) Epilepsy? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 9) Diabetes or glands? <input type="checkbox"/> YES <input type="checkbox"/> NO | 19) Genito-urinary system? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 10) Cancer, tumor, cyst, or growth? <input type="checkbox"/> YES <input type="checkbox"/> NO | 20) Reproductive system? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 11) Stomach, bowel or intestines? <input type="checkbox"/> YES <input type="checkbox"/> NO | 21) Have you ever been treated for or had any indication of physical disorder, injury or abnormality, not disclosed elsewhere on this application? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 12) Kidney, liver or gall bladder? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13) Lung or respiratory system? <input type="checkbox"/> YES <input type="checkbox"/> NO | 22) Have you ever applied to Lloyd's for Medical coverage in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 14) Sight or Hearing? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 15) Mental or nervous system? <input type="checkbox"/> YES <input type="checkbox"/> NO | |

****PLEASE REMEMBER TO ATTACH A SEPARATE SHEET WITH ALL DETAILS TO ANY YES ANSWERS ABOVE****

DECLARATION (Please Read Carefully)

I read and/or understand English. I have read the above statements. I declare that the above information is true and complete to the best of my knowledge and belief. Apart from the matters disclosed above, I am in good health and ordinarily enjoy good health. In the event of fraud, misstatements, concealment, or failure to disclose information on this application, whether intentional or inadvertent, any insurance issued based upon this application may become void and no benefits will be payable. **Binding Arbitration—Waiver of Right to Trial by Jury:** I understand and agree that any disputes concerning this insurance must be submitted to binding arbitration if the amounts 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. I acknowledge that I reside outside the United States for more than 5 months per year, rendering me ineligible for coverage through standard medical insurance carriers.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health, to give to the Petersen International Underwriters.

Date: _____

Signature of Proposed Insured



THE WORLDWIDE MAJOR MEDICAL PLAN

To be
Eligible for Benefits,
you must reside outside
the United States for
more than 5 months
per year.

THE WORLDWIDE MAJOR MEDICAL PLAN WORKS LIKE THIS:

Deductibles: You may choose a \$500, \$1,000, \$2,500, or \$5,000 per person per Illness or Injury Deductible Amount.

Coinsurance: After the Deductible is paid, Underwriters will reimburse 80% of the next \$5,000 in Eligible Expenses and then 100% up to the Maximum Benefit.

Maximum Benefit: \$5,000,000 per person per lifetime

LIMITED BENEFITS AVAILABLE FOR:

- MATERNITY
- MENTAL AND NERVOUS CONDITIONS
- PRE-EXISTING CONDITIONS
- CARDIAC CONDITIONS

ELIGIBLE EXPENSES

Treatment may be received anywhere in the world excluding the U.S.A. or for an additional premium the U.S.A. may be covered as well. This coverage is secondary to medical benefits, services, or reimbursements from any other source except Medicaid. Underwriters will reimburse the Eligible Expenses incurred, listed below, when Medically Necessary for the diagnosis and treatment of an Illness or Injury, subject to the terms and limitations described in the Certificate.

- Hospital room and board (limited to the semi-private daily rate).
- Hospital intensive care unit.
- Other Medically Necessary Hospital services and supplies, such as emergency room care, outpatient surgery, diagnostic services, supplies and therapy.
- Skilled Nursing Facility room and board, if confinement begins within 30 days following a Medically Necessary Hospital confinement of three days or longer.
- Home Health Care, if hospitalization would have been required if Home Health Care were not provided, and the care is provided in accordance with a written plan established and approved by a Physician.



- Physician services consisting of home, office, and hospital visits, and any other medical care and treatment.
- Local area ambulance service.
- Diagnostic services, supplies, and therapy.
- Outpatient medications prescribed by a treating physician following any hospitalization.

RENEWAL AGREEMENT

This coverage is conditionally renewable based upon residency requirements and payment of premium. Underwriters reserve the right to modify coverage by class.

10 Day Free Look

If, for any reason, you are not satisfied with the insurance described in the Certificate you have the right to return the Certificate within 10 days of its delivery to you and your premium will be fully refunded.

*This is not intended to be a complete outline of coverage.
Actual wording may change without notice.*



THE WORLDWIDE MAJOR MEDICAL PLAN

OPTIONAL COVERAGES

Hazardous Sports or Activities

If you elect this option, Underwriters will reimburse you for eligible expenses which are incurred due to an injury resulting from the participation in a Hazardous Sport or Activity that is specifically named on the Schedule of Benefits.

All-cause Deductible

If you elect this option, you will only need to meet the deductible and coinsurance specified in the Schedule of benefits one time, for each person, regardless of how many separate injuries or illnesses you have per annum.

LIMITATIONS

Expenses which have limitations are as follows:

- 1) Maternity, normal delivery and/or well baby care covered after 15 months, to a maximum of \$5,000 per year. Complications of pregnancy covered as any other condition after 15 months.
- 4) Mental and Nervous Disorders covered to \$5,000 lifetime maximum for outpatient visits. Disorders necessitating hospitalization shall be covered as any other condition.

EXCLUSIONS

Expenses which are not eligible for reimbursement are as follows:

- Any expense which you are not legally obligated to pay.
- Services which are not Medically Necessary and are not furnished by or under supervision of a Physician.
- Expenses for services and supplies for which you are entitled to benefits, services, or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan, or from any other source, except Medicaid.
- Expenses in excess of Usual, Customary, and Reasonable fees.
- Outpatient drugs, except following a hospitalization if prescribed for the same illness or injury.
- Self-inflicted injuries while sane or insane.
- Treatment for alcoholism, drug addiction, and/or allergies.
- Rest cures, quarantine, or isolation.
- Cosmetic surgery, unless necessitated by an accidental injury.
- Dental exams, dental x-rays, and general dental care except as a result of an accidental injury.
- Eye glasses or eye examinations.
- Hearing aids or hearing examinations.
- General or routine examinations.
- Injuries sustained from participation in hazardous sports or activities which include: Professional or recreational: mountaineering, snow skiing, scuba diving, hang gliding, sky diving, bungee jumping, racing of any kind, and all professional and semiprofessional sports.
- Pregnancy and pregnancy-related conditions including, but not limited to, fertility, pre-natal care, childbirth, miscarriage, or abortion until a minimum of 15 months has elapsed, subject to the Terms and Limitations in the Certificate.
- Injuries due to war or any act of war whether declared or undeclared.
- Injuries sustained while committing a criminal or felonious act.
- Expenses incurred for, or resulting from, pain which is not supported by medical diagnosis.
- Cataract surgery which is not considered an emergency and/or which is performed at Your discretion.
- Any elective surgery.
- Custodial Care.
- Pre-existing conditions not disclosed on the application.

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THE WORLDWIDE MAJOR MEDICAL PLAN

THE WORLDWIDE MAJOR MEDICAL PLAN RATES

(Excluding Coverage in U.S.A.)

To include U.S.A. coverage all premiums to be multiplied by 2

ANNUAL PREMIUMS

AGE	\$500 DEDUCTIBLE		\$1,000 DEDUCTIBLE		\$2,500 DEDUCTIBLE		\$5,000 DEDUCTIBLE	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
0-9	162.50	162.50	125.00	125.00	112.50	112.50	100.00	100.00
10-18	175.50	175.00	137.50	137.50	125.00	125.00	112.50	112.50
19-24	425.00	737.00	325.00	500.00	287.50	450.00	225.00	362.50
25-29	475.00	812.50	362.00	575.00	312.50	500.00	250.00	400.00
30-34	500.00	900.00	375.00	650.00	325.00	575.00	262.50	462.50
35-39	550.00	937.50	425.00	725.00	362.50	625.00	287.50	500.00
40-44	612.50	775.00	462.50	575.00	400.00	500.00	325.00	412.50
45-49	687.50	850.00	525.00	650.00	450.00	575.00	362.50	425.00
50-54	837.50	937.50	625.00	700.00	575.00	650.00	462.50	512.50
55-59	1,025.00	1,025.00	787.50	787.50	687.50	687.50	562.50	562.50
60-64	1,362.50	1,287.50	1,112.50	1,000.00	1,000.00	937.50	800.00	712.50
65-69	2,650.00	2,275.00	2,175.00	1,825.00	1,725.00	1,500.00	1,375.00	1,200.00
70	3,000.00	2,550.00	2,700.00	2,300.00	2,000.00	1,700.00	1,600.00	1,362.50
71	3,200.00	2,750.00	2,825.00	2,425.00	2,175.00	1,837.50	1,700.00	1,470.00
72	3,475.00	3,000.00	2,975.00	2,550.00	2,350.00	2,000.00	1,880.00	1,600.00
73	3,775.00	3,275.00	3,125.00	2,700.00	2,525.00	2,187.50	2,020.00	1,750.00
74	4,087.50	3,575.00	3,300.00	2,825.00	2,750.00	2,400.00	2,200.00	1,925.00

UNDERWRITING NOTES

One application per person. A family will be added onto one certificate. A photocopy of the application is acceptable.

Please do not send money with the application. The earliest effective date is 24 hours after approval, or the requested effective date (up to 30 days following the approval of the application).

HOW TO CALCULATE

- 1) Use actual age.
- 2) Add up all insureds.
- 3) Multiply by 2 if U.S.A. coverage is required.
- 4) Add \$100 processing fee.

OPTIONAL BENEFITS

Recreational Scuba	add 10% or \$80 whichever is greater
Recreational Snow Skiing	add 10% or \$80 whichever is greater
All-cause Deductible	add 15%

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THE WORLDWIDE MAJOR MEDICAL PLAN

An International Major Medical Series Product

The Worldwide Major Medical Plan

Because the World is Dynamic—Not Stationary!

Why The Worldwide Major Medical Plan?

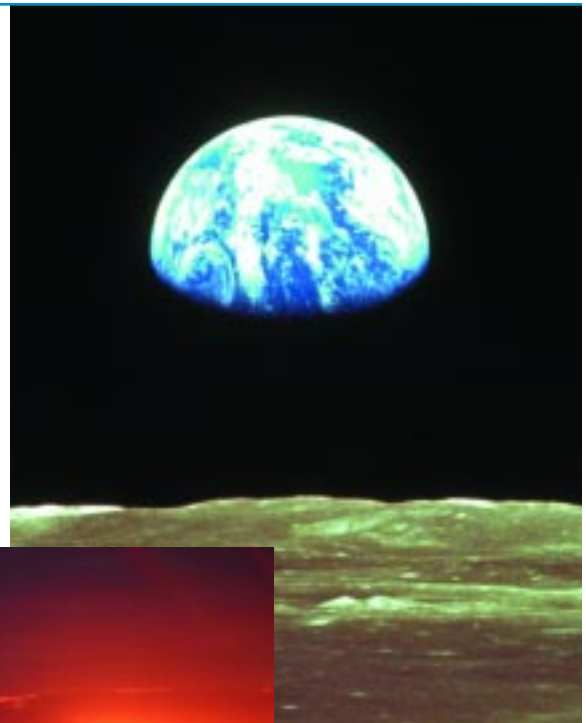
The Worldwide Major Medical Plan began in development several years ago.

Traditional medical insurance assumes that the insured never ventures far away from a managed care facility. Having a population remain in one place is the only way a managed care program can function. This still remains true and is an important part of health insurance in the United States. Most carriers, and even countries with socialized healthcare access, often are not capable of claims administration on an international basis.

However, traditional medical plans and even the supplemental travel medical plans became limited with a new type of individual needing medical insurance — The global citizen!

Many U.S. citizens have found themselves residing outside the United States either permanently or for an unknown period of time. These people need medical coverage in the country in which they are residing, but also may desire coverage that if something serious happened, they could use the coverage for treatment in the United States. These same people also may travel to other locations necessitating a portable international medical plan.

The Worldwide Major Medical Plan provides valuable benefits in any country in which a person is located and even may provide benefits available for treatment back in the United States.



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