PHYSICIANS & SURGEONS HIGH LIMIT

The following Bridge Plan application should be completed and submitted as follows:

Complete:

1. To complete the application on line, tab to each area and type it in. To place checks in the boxes, you can either use the space bar or your mouse. Print, sign and date the application and fax it back with this completed cover sheet.

   or

2. Print the application; complete each area by hand or typewriter. Print, sign and date it and fax it back with this completed cover sheet.

Submit:

1. Make sure all information below is completed then fax or mail both pages to Petersen International Underwriters, 23929 Valencia Boulevard, Suite 215, Valencia, CA. 91355

TO:	New Business Department	FAX:	661 - 254-3717
		PHONE:	661 - 254-0006
		E-Mail:	Kathyjean@piu.org
FROM:		FAX:	
		PHONE:	
		E-Mail:	
AGENT:	Medical Management Company	FAX:	
(If applicable)	3059	PHONE:	(626) 796-6113
		E-MAIL	

COMMENTS:

Thank you

MONTHLY DISABILITY BENEFITS

Proposed Use of This Insurance:

	BENEFIT	ANNUAL PREMIUM
MONTHLY BENEFIT AMOUNT	$ ______	$ ______
ELIMINATION PERIOD	______ Days	
BENEFIT PERIOD	______ Months	
MAXIMUM BENEFIT, EACH CLAIM	$ ______	
TERM OF INSURANCE	______ Years	
OPTIONAL BENEFITS:		
RESIDUAL DISABILITY RIDER		$ ______
COST OF LIVING ADJUSTMENT RIDER		$ ______
OWN OCCUPATION RIDER		$ ______
TOTAL ANNUAL PREMIUM		$ ______

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

FINANCIAL INFORMATION: ❑ Confidential Financial Statement ❑ Tax Returns ❑ ______

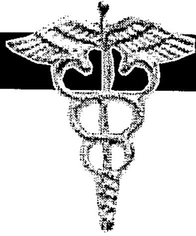
SPECIAL FEATURES

- **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 as a medical doctor.
- **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:** Total Disability benefits will be paid to you while disabled following surgery in which 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.

OPTIONS

- **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.
- **COST OF LIVING ADJUSTMENT (COLA):** Benefits will annually automatically increase based upon the Consumer Price Index (CPI), but not to exceed 10% per year.
- **OWN OCCUPATION:** Benefits will be paid to you during the first 24 months of disability when due to sickness or injury you cannot perform the substantial and material duties of your regular occupation, thereafter benefits will be determined by the standard medical occupation definition.

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:

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 as a medical doctor.

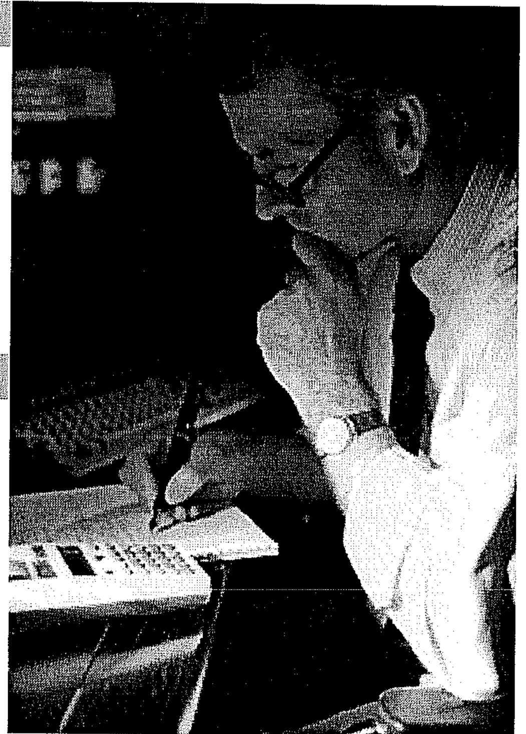
	BENEFIT	ANNUAL PREMIUM
BENEFIT AMOUNT	$ ______________	$ ______________
ELIMINATION PERIOD	_______ Months	
TERM OF INSURANCE	_______ Year(s)	

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

FINANCIAL INFORMATION: ❑ Confidential Financial Statement ❑ Tax Returns ❑ ______________

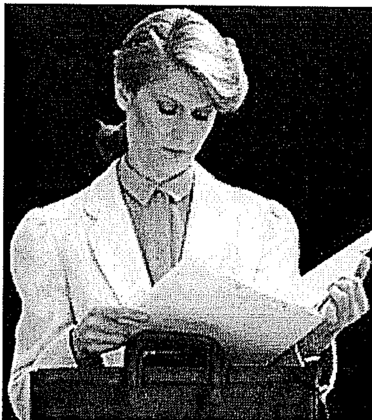
BENEFIT PROVISIONS

- The **Lump Sum Disability Benefit** may stand alone or may be designed to be paid at 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.



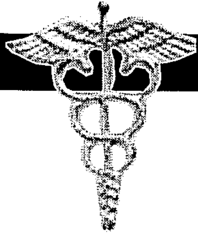
CONDITIONS

- You must be totally disabled and under the regular care of a physician during the elimination period and at the end of such period your physician must determine that you are permanently totally disabled as a Medical Doctor.



- 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

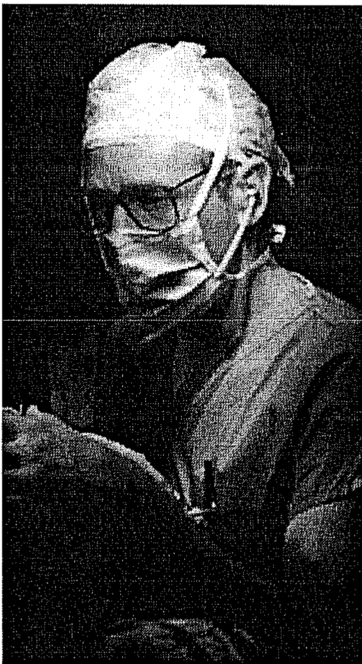
TERM OF INSURANCE is the time period during which the provisions of the certificate or the rates charged cannot be changed by the Underwriters. On the renewal date following a Term of Insurance the Underwriters reserve the right to not offer a new Term of Insurance or to offer a new Term of Insurance with modified provisions or rates.

THIS IS A SPECIFIC OCCUPATION certificate. The plan will automatically terminate if you change your occupation to something other than was declared on the certificate as 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 a termination because of 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 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:
2. a. Sex: b. Age:
   c. Date of Birth:
   d. Place of Birth:
   e. Soc. Sec. No.

3a. Occupation :
b. Material duties which account for the majority of your income:
c. Substantial duties which account for most of your work time:

4a. Name & Address of Employer:
b. Length of service:
c. Are you actively at work? ☐ Yes ☐ No

5. Residence Address:
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 Face Amount	Disability Monthly Benefit	Disability Lump Sum	Benefit Period	Personal	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. **Section I – Monthly Benefit Plan**
☐ 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 – Lump Sum Benefit Plan
☐ Personal Disability ☐ Key Person
☐ Bank Loan Indemnification ☐Buy/Sell ☐ ____________

Accident and Sickness Permanent Total Disability

Elimination Period Requested ____________ months
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. 21 ☐ 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

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

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. ______ lbs. | b. How much has your weight changed in the last year? ☐ None ☐ Gain lbs. ☐ Loss lbs. ______ lbs. | c. Marital status: ______

25. Have you, to the best of your knowledge ever been treated for or had any indication of the following?

a. Disorder of eyes, ears, nose or throat? ☐ Yes ☐ No

b. Headaches, fainting, unconsciousness, convulsions, concussions, paralysis, or any disorder of the brain or nervous system? ☐ Yes ☐ No

c. Tuberculosis, asthma, or any disorder of the lungs or respiratory system? ☐ Yes ☐ Noi.

d. Chest pain, high blood pressure, heart murmur, or any disorder of the heart, spleen, blood, blood vessels or circulatory system? ☐ Yes ☐ Nol

e. Disorder of the digestive system including stomach, intestines or bowel, liver, rectum, appendix, or gall bladder? ☐ Yes ☐ No

f. Disorder of genito-urinary system including kidneys, bladder or any other urinary disorder? ☐ Yes ☐ No

g. Rheumatism, gout, arthritis or any deformity or disorder of the spine, muscles, bones or joints? ☐ Yes ☐ No

h. Diabetes, disorder of the thyroid, pancreas or lymph nodes, or any disorder of the glands? ☐ Yes ☐ No

Cancer, tumor, cyst or growth? ☐ Yes ☐ No

j. Any allergies of any sort or disorders of the skin? ☐ Yes ☐ No

k. Hernia, or any disorder of the reproductive system? ☐ Yes ☐ No

. Are you now pregnant? ☐ Yes ☐ No

m. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told you had AIDS or ARC (AIDS related complex)? ☐ Yes ☐ No

n. Any physical disorder, injury, or abnormality within the last 5 years, not disclosed in the answers above (No. 25 a-m) ☐ 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? ☐ Yes ☐ No

b. Within the last 5 years have you ever had or been advise to have a surgical operation or hospitalization? ☐ Yes ☐ No

c. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests? ☐ Yes ☐ Noh.

d. Are you now taking medication? ☐ Yes ☐ No

e. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness? ☐ Yes ☐ No

f. Have you ever received treatment or joined an organization for alcoholism or drug dependence? ☐ Yes ☐ No

g. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other similar drugs? ☐ Yes ☐ No

Have you ever used tobacco at any time within the past 12 months? ☐ Yes ☐ No

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

LIFE & 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 application on myself. This is furnished as a true and accurate statement of my financial condition as of:

____________, 20 ______

	Column (A) CURRENT YTD	Column (B) LAST YEAR	Column (C) TWO YEARS AGO
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	$ ______	$ ______	$ ______
Royalty Income	$ ______	$ ______	$ ______
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
23929 Valencia Blvd., Suite 215 • Valencia, California 91355
Tel (661) 254-0006 - Fax (661) 254-0604 - (800) 345-8816

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 to 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