

# THE WORLDWIDE MAJOR MEDICAL PLAN



## GIC Insurance Agency

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### **WORLDWIDE COVERAGE FOR**

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



**New  
All Cause  
Deductible**

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[www.piu.org](http://www.piu.org)



# 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 period of insurance.

**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 (Ages 0 through 69)**

**Maximum Benefit: \$500,000 per person per lifetime (Ages 70 through 74)**

## LIMITED BENEFITS AVAILABLE FOR:

- MATERNITY
- MENTAL AND NERVOUS 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.
- Local area ambulance service.



- Physician services consisting of home, office, and hospital visits, and any other medical care and treatment.
- Diagnostic services, supplies, and therapy.
- Prescription medication prescribed at the time of discharge from the hospital, not to exceed a 12 month benefit period.

## 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.

### War or Act of War Coverage

If you elect this option, underwriters will reimburse you for eligible expenses which are incurred as a result of injuries sustained due to war or act of war.

### Global Medical Transportation

If you elect this option, underwriters will reimburse you for all medically necessary expenses for stabilization and transportation to the facility nearest your home, which can provide the appropriate care.

## 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.
- 2) 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 in part include: Professional or recreational: mountaineering, snow skiing, scuba diving, hang gliding, skydiving, 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. Terrorism however is included in the policy benefits.
- 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
10-17*	175.50	175.00	137.50	137.50	125.00	125.00	112.50	112.50
18-24	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	N/A	N/A	2,700.00	2,300.00	2,000.00	1,700.00	1,600.00	1,362.50
71	N/A	N/A	2,825.00	2,425.00	2,175.00	1,837.50	1,700.00	1,470.00
72	N/A	N/A	2,975.00	2,550.00	2,350.00	2,000.00	1,880.00	1,600.00
73	N/A	N/A	3,125.00	2,700.00	2,525.00	2,187.50	2,020.00	1,750.00
74	N/A	N/A	3,300.00	2,825.00	2,750.00	2,400.00	2,200.00	1,925.00

\*If applying with an adult, otherwise use 18-24 rates

### 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 optional hazardous sports/activities.
- 5) Add \$100 processing fee.
- 6) Global Medical Transportation - 30% rate
- 7) War or Act of War Coverage - please call

### OPTIONAL HAZARDOUS SPORTS/ACTIVITIES BENEFITS

Recreational Scuba	add 10% or \$80 whichever is greater
Recreational Snow Skiing	add 10% or \$80 whichever is greater
All other Hazardous Sports/Activities	Call Petersen International Underwriters

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

*Underwriters reserve the right to modify terms and benefits at time of underwriting*



# 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.



## PETERSEN INTERNATIONAL UNDERWRITERS

*Lloyd's Correspondents*

23929 Valencia Boulevard Suite 215 Valencia California 91355-2186

Telephone (800) 345-8816 Facsimile (661) 254-0604 E-Mail: [piu@piu.org](mailto:piu@piu.org) Website: [www.piu.org](http://www.piu.org)



# The Worldwide Major Medical Plan

GIC Insurance Agency  
P.O. Box 291 Fair Grove, Missouri 65648  
Phone:(417) 759-2009 • Fax: (417) 459-4870  
www.gicinsurance.com • info@gicinsurance.com

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.

Proposed Insured: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Gender:  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

USA Address: Number & Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact Information: E-mail Address \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Citizenship: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: Name \_\_\_\_\_ Address \_\_\_\_\_

Date & Reason Last Seen: Date \_\_\_\_\_ Reason Seen \_\_\_\_\_ Results \_\_\_\_\_

Time Outside USA: \_\_\_\_\_ Months — Must be at least 5 months over the next 12 month period.

Effective Date : \_\_\_\_\_ Deductible:  \$500  \$1,000  \$2,500  \$5,000

Plan Type:  Worldwide  Worldwide Excluding The USA

Optional Coverages:  Global Medical Transportation Including Repatriation of Remains  
 Sports or Activities Coverage — Specify Sport or Activity \_\_\_\_\_  
 War Coverage

## Medical History

Questions 1-5 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 in the provided area below and if additional space is required please attach a separate sheet and submit it with the application. Please attach these responses to this application. The Underwriters may request additional medical information.

1. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you currently disabled or unable to perform normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been declined or accepted on a modified term basis for life, disability or medical insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever received treatment or joined an organization for alcoholism or drug dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), Lymphadenopathy Syndrome, or any Immune System Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Medical History - Continued

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**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 in the area provided below or in additional space is needed please use a separate sheet and submit the it along with the application. Please attach these responses to this application. The Underwriters may request additional medical information.**

Questions 1-16 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:

1. Heart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Blood Vessels or circulatory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Blood Pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes or glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Cancer, tumor, cyst, and/or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Stomach, bowel and/or intestines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Kidney, liver and/or gall bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Lung and/or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Eyes, ears, nose, and/or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Mental and/or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Bone, skeleton, muscles, joints and/or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Genitourinary system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Back pain, Slipped Disc, and/or herniated disc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. 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
18. Have you been advised or recommended to receive medical attention that has not been received?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have you ever undergone a surgical operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you suffered from fainting episode, blackout, headache, migraines, seizures, and/or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Do you have any reason to believe that a surgical operation will be necessary in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Any other medications taken in the past 12 months? If Yes, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Are you currently taking medication? If Yes, please provide reason taking and medication.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DECLARATION - 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.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PETERSEN INTERNATIONAL UNDERWRITERS**

23929 Valencia Boulevard, Suite 215, Valencia, California 91355

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

Website: <http://www.piu.org> E-Mail: [piu@piu.org](mailto:piu@piu.org)

**AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION**

**This Authorization complies with the HIPAA Privacy Rule**

I, \_\_\_\_\_ hereby acknowledge this Authorization to Release Health  
(Proposed Insured/Patient)  
Related information.

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment which includes, but is not limited to:

Physicians

Hospitals

Clinics

Medically related facilities

Rehabilitation facilities

Laboratories

Other/Specific: \_\_\_\_\_

\_\_\_\_ Proposed Insured/Patient Initials

to disclose my medical records to Petersen International Underwriters (or its assigned 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, but not be limited to:

Patient Histories

Progress notes

Test results

X-rays

Psychiatric Evaluations

Drug and/or Alcohol Treatment information

HIV Test Results and/or

Other diagnostic information

\_\_\_\_ Proposed Insured/Patient Initials

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature (if by someone other than the Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

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 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 is signed unless a different date is specified here: \_\_\_\_\_.

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature (if by someone other than the Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

# **Petersen International Underwriters Privacy Policy Statement**

## **Petersen International Underwriters**

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

### **Information We Collect**

We collect non-public information about you from numerous sources including, but not limited to:

- a) Information we receive from you on applications and other forms;
- b) Information about your transactions with our affiliates, others or us;
- c) Information we receive from consumer-reporting agencies; and
- d) Financial and medical sources.

### **Information We Disclose**

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

### **Right to access or correct your personal information**

You have a right to request access to or correction of your personal information in our possession.

### **Confidentiality and Security**

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

### **Contacting Us**

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: [piu@piu.org](mailto:piu@piu.org)