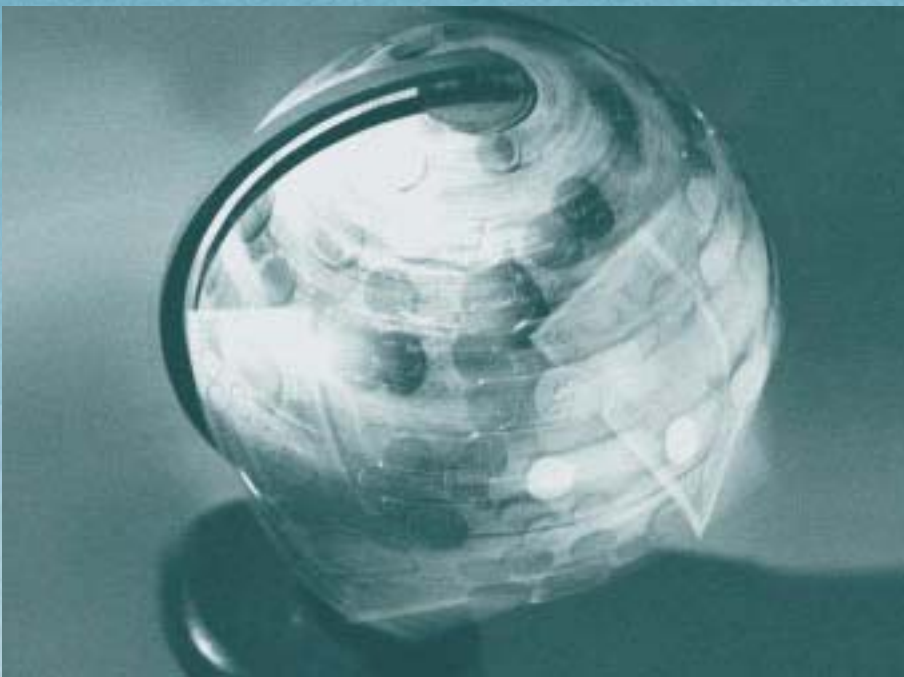


# INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE



## **FOR**

*U.S. Dollar Term Life Insurance for use when there is an international insurable interest involved.*

## **USES**

*Employees of Foreign National Firms  
International Asset Protection  
International Business Travel  
Short Term Needs  
Special Assignments*



**GIC Insurance Agency**

P.O. Box 291 Fair Grove, Missouri 65648

Phone:(417) 759-2009 • Fax: (417) 459-4870

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# INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE

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

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ SMOKER: \_\_\_\_\_ DATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

POLICY PERIOD: A) \_\_\_\_\_ B) \_\_\_\_\_ C) \_\_\_\_\_

FACE AMOUNT: A) \$ \_\_\_\_\_ B) \$ \_\_\_\_\_ C) \$ \_\_\_\_\_

ANNUAL PREMIUM: A) \$ \_\_\_\_\_ B) \$ \_\_\_\_\_ C) \$ \_\_\_\_\_

UNDERWRITING REQUIREMENTS:  Application  Exam  Blood & Urine  EKG  Financial Justification  
 Other \_\_\_\_\_

## POLICY FEATURES

### Policy Periods

International Term life Insurance is available for time periods from 1 month up to a maximum of 10 years, on a level premium basis. During the policy period requalifying is not required and the premiums are payable on an annual basis.

### Issue Ages

From ages one year to seventy-five years.

### How to Obtain a Rate Indication

**Geographical Limitations:** Most policies are written for world-wide coverage. There are certain areas in the world where restrictions or limitations may apply. It is important to obtain as much information regarding travel and place of residency as possible. Be specific on city and country.

**Financial Justification:** Whether the insurance is for business use or personal use, financial justification is critical to successful underwriting. Please be sure there is adequate justification for the amount to be insured.

**Occupations:** Before assigning a premium to a risk the determination of the insured's occupational duties and the amount of travel related to their work assists us in developing accurate rates.

**Avocation:** Please advise as to any hazardous sports or recreational activities in which the proposed insured may be involved.

**Purpose of Coverage:** Developing a clear picture as to the importance of this insurance aids the underwriters in developing the best possible rates.

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



# International / Special Use Term Life Insurance Application

Producer #19917

Before any question is answered, please read carefully the Declaration at the end of this application form, which must be signed and dated. Please ensure that all questions are answered fully and correctly by the person to be insured. Any question left unanswered will delay the assessment of the application for insurance.

NO INSURANCE IS IN FORCE UNTIL THIS APPLICATION HAS BEEN ACCEPTED AND APPROVED BY UNDERWRITERS AND THE FIRST PREMIUM HAS BEEN PAID.

### Proposed Insured's Personal Information -

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female Marital Status: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_ Nationality: \_\_\_\_\_ Citizenship: \_\_\_\_\_  
Social Security Number or Passport Number: \_\_\_\_\_ Number of dependents: \_\_\_\_\_  
Country Issued (Passport): \_\_\_\_\_

### Legal Residence & Contact Information -

Street & Street Number: \_\_\_\_\_  
City: \_\_\_\_\_  
Country: \_\_\_\_\_  
Postcode: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

### Beneficiary Information -

Name of first beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name of contingent beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Proposed Policy Owner - if other than the Insured Above -

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Country: \_\_\_\_\_

Details of Insurable Interest and/or Relationship to the Proposed Insured: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Personal Finance Details -

Annual Income from Occupation: \_\_\_\_\_  
Other Income and Source of Other Income: \_\_\_\_\_  
Net Worth: \_\_\_\_\_  
Have you or any business owned in whole or in part by you ever been in bankruptcy:  Yes  No



# International / Special Use Term Life Insurance Application

## Policy Details -

Sum Insured Applying For: \_\_\_\_\_

Term of Policy: \_\_\_\_\_ Year(s)

Send Premium Notice To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Premium Frequency Requested:  Annual  Semi annual  Quarterly

Requested Effective Date: \_\_\_\_\_

Details as to the reasons for this insurance: \_\_\_\_\_

## Other Insurance -

Details of any other life insurance in force or intending to be put into force: \_\_\_\_\_

<u>Insurer</u>	<u>Approximate Date of Issue</u>	<u>Life Insurance Sum Insured</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is replacement of any insurance involved with this transaction:  Yes  No If Yes please provide details \_\_\_\_\_

## Occupational Details -

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Employer's Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Country: \_\_\_\_\_

### Does your occupational duties involve in any way: (if yes please provide details)

- Tradesman work:  Yes  No
- Entertainment:  Yes  No
- Working at heights:  Yes  No
- Working offshore:  Yes  No
- Any aviation exposure other than scheduled airlines:  Yes  No
- Diving or fishing:  Yes  No
- Mining or working underground:  Yes  No
- The use of special safety precautions:  Yes  No
- Military involvement:  Yes  No
- Any activity that might be considered hazardous:  Yes  No



# International / Special Use Term Life Insurance Application

## Personal Details -

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. Has your weight changed within the last 12 months:  None  Gain \_\_\_\_\_  Loss \_\_\_\_\_
2. Have you used any form of tobacco within the last 12 months:  Yes  No
3. Do you drink alcohol:  Yes  No Consumption per week: \_\_\_\_\_
4. Have you ever been medically advised to reduce your alcohol consumption?  Yes  No
5. Have you ever used drugs on a recreational basis?  Yes  No
6. Have you consulted any doctor, hospital, or clinic within the last 5 years, other than for clearly minor conditions such as colds, flu, etc.:  Yes  No
7. Are you taking any medicine or drugs whether or not prescribed by a physician or receiving any treatments of any kind:  Yes  No

## Have you ever suffered from or been diagnosed with -

- |  |  |
|--|--|
| 8. Anxiety, Depression, or other Mental or Nervous disorder: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Any Chest or Lung disorder:                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Any disorder of the blood:                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Any operation:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Any Stomach or Bowel complaints:                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Arthritis:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Bladder problems:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Cancer:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Chest pain:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Cyst:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Diabetes:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Disorder of the brain or spinal cord:                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Dizziness, convulsions, neurological disorder            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Epilepsy:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Gout:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Heart disease:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Hepatitis B or C:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. High Blood Pressure:                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. HIV / AIDS:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Kidney problems:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Liver problems:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 29. Lump:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 30. Prostate problems:                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 31. Rheumatic fever:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 32. Sexually transmitted disease:                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 33. Stroke:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 34. X-Ray, MRI or other special tests:                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Number and Details:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# International / Special Use Term Life Insurance Application

Have any of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer or a nervous disorder:  Yes  No

Has any application for insurance on your life or health been declined, withdrawn by yourself or accepted with special terms:  Yes  No

To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as previously described?  Yes  No

### Travel and Activities -

Do you engage in any hazardous sports or pastimes such as a private aviation, motor sports, diving, skiing or boarding, etc.  Yes  No

Do you anticipate travel outside your normal country of residence, Western Europe, North America or Australia:  Yes  No

### Important Notes -

Please note that your answers to the questions on this application form will be used to assess the ability for us to offer you insurance. All material facts must be disclosed since part or all of the benefit that this insurance is to provide might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of this application. If you are unsure whether a particular fact is material you should disclose it. Insurance coverage will not start until we have accepted your application and the first premium has been paid. If you have a birthday while your application is being underwritten, the terms may differ from those originally quoted. We may ask you to contact your doctor to speed up the completion of reports that we may have requested. Both Petersen International Underwriters and our Life Underwriters have Confidentiality Policies in place. If you require a copy of such please contact our office.

### Declarations -

It is understood and agreed that all the answers to the above questions, to the best of my knowledge and belief, are true and complete; 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 this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void in part or in whole with benefits not being payable; and the insurance hereunder applied for shall take effect on the date set forth on the certificate of insurance, 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 the application and the effective date of the certificate.

I have read the application, Important Notes and Declarations.

Signature of life to be insured: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Policy Owner: \_\_\_\_\_ 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, \_\_\_\_\_ (Proposed Insured/Patient) hereby acknowledge this Authorization to Release Health 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)