

Pilot's Disability Insurance

"Temporary Loss of License"

Disability Insurance
for People Who Fly
For a Living

Commercial Pilots

Corporate Pilots

Cargo Pilots

Aerial Applicators

Agricultural Pilots

Firefighter Pilots

Air Show Pilots

Test Pilots

Air Ambulance Pilot

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

Proposal For: _____

Age: _____ **Date:** _____

Presented By: _____

Pilot's Disability Insurance

Flight Category:

☐ Commercial Pilot ☐ Corporate Pilot ☐ Cargo Pilot ☐ Firefighting Pilot ☐ Air Ambulance Pilot

☐ Agricultural Pilot ☐ Aerial Applicator ☐ Air Show Pilot ☐ Test Pilot

Aircraft Category:

☐ Fixed Wing ☐ Helicopter

Monthly Benefits are payable while Totally Disabled beginning the first day following the Elimination Period and for as long as the Benefit Period **for each disability.**

	Benefit Schedule	Annual Premium
Monthly Benefit amount	$ _____	$ _____
Elimination Period	_____ Days	
Benefit Period	_____ Months	
Maximum Benefit Each Claim	$ _____	
Optional residual Disability rider		$ _____
Optional Cola Rider (CPI) 10%		$ _____
Total Annual Premium		$ _____
Term of Insurance _____ Years		

Underwriting requirements:

☐ Application ☐ Medical Exam ☐ Blood & Urine ☐ EKG ☐ other:_____

Financial information:

☐ Confidential Financial Statement ☐ Tax Returns ☐ other:_____

Options

Residual Disability Rider Benefits are payable when you are engaged in your regular occupation, or another occupation, and you experience reduced income of 20% or more, due to a disability. The benefit amounts will be calculated by multiplying the monthly benefit amount by the percentage of reduced income compared to the average monthly earned income received during the twelve-month period preceding the onset date of the disability.

Optional Cost of Living Adjustment (COLA) will automatically increase the monthly benefit each year based upon the Consumer Price Index (CPI), but not to exceed 10% per year.

Air Travel

This policy, subject otherwise to its terms, limitations and conditions covers claims arising out of bodily injury sustained by the insured person while flying as a pilot or crew member, in any aircraft for which the insured person holds a current valid license or as a passenger in any aircraft including boarding and alighting.



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



Definitions

Total Disability Monthly Benefits are payable when, due to sickness or injury, you cannot perform the substantial and material duties of your regular occupation and you are under the regular care of a legally qualified physician.

Sickness, illness means a Sickness or disease which You are first diagnosed by a Physician while this certificate is in force causes You to be disabled that begins within 365 days from the date such Sickness or disease was first diagnosed.

Accident, Injury means accidental bodily Injury sustained by the insured person, which are the direct cause of loss, independent of disease or bodily infirmity.



Elimination Period means the number of consecutive days You are Totally Disabled or Residually Disabled if the Residual Rider was purchased, before a benefit is payable. The Elimination Period begins on the first day You are attended by a Physician who determines You to be Totally Disabled and/or Residually Disabled.

Maximum Benefit Period means the overall maximum number of months that benefits will be paid during any one period of Total Disability.

Term of Insurance

The Certificate of Insurance is issued for a period of 1 to 3 years. It is contemplated that the plan will be renewed, however, the underwriters reserve the right to refuse to renew the Certificate or to change the terms and/or the premium rates on renewal of the Certificate. A statement of good health or new application may be required by the underwriters for consideration of renewal. Non-renewal by the Insurer will be without prejudice to any claim in connection with a loss commencing while this plan is in force.

Special Features

Recurrent Disabilities:

If after a period of Total Disability You resume occupation and You work at that occupation on a full time basis for a continuous period of at least 6 months, any Total Disability that begins after that time will be considered a new disability, even if it is a recurrence of the same condition that previously disabled You. If You do not work at least 6 consecutive months any later Total Disability will be considered as the same prior disability. If a new disability results from a cause entirely different and unrelated to the prior disability, such disability is subject to a new Elimination Period and Maximum Benefit Period.

Presumptive Disability:

You will be presumed to be Totally Disabled, if due to an Accident or Sickness You have totally lost: the use of both hands, or both feet, or one hand and one foot, or the sight of both eyes, or hearing of both ears, or the ability to speak. The Elimination Period will be waived. Regular Care is not required. The covered Monthly Benefits will be paid as long as the loss exists, up to the Maximum Benefit Period.

Transplant Benefits:

If this certificate has been in force for at least 6 consecutive months and You donate on organ from Your body to another person, the Total Disability which results from such surgery will be considered a Sickness. Benefits will be payable in the same manner as those for any other Sickness.

Pilot's Disability Insurance Application

Part 1

To: PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Blvd. Site 215 Valencia CA 91335 Tel (800) 345-8816 Fax (661) 254.0604

Personal Information

1. **Name:** first _____ middle _____ last _____

Address: number & street _____

city _____ state _____ zip _____

Date of Birth: _____ **Place of Birth:** _____ **Height:** _____ **Weight:** _____

Telephone: _____ **Fax:** _____ **E-mail:** _____

Flight Category: ☐ Air Show Pilot ☐ Test Pilot ☐ Commercial Airline Pilot ☐ Corporate Pilot ☐ Firefighter Pilot
☐ Agricultural Pilot ☐ Aerial Applicator ☐ Cargo Pilot

Aircraft Category: ☐ Fixed Wing ☐ Helicopter

2. **Employer:** a) Flying Occupation _____
b) Non-Flying Occupation _____

3. **Salary or Earned Income:** a) Flying Occupation: $ _____ b) Non-Flying Occupation: $ _____

4. **Insurance for which you are applying:** a) Monthly Benefit Amount: $ _____ b) Elimination Period: ___ days c) Benefit Period: ___ months

Flying information

5. **Current Licenses:** ☐ Flight Instructor ☐ Commercial ☐ Instrument Flight Rating
☐ Airline Transport Rating ☐ Rotorcraft ☐ Multi-Engine

a) Date of Last FAA Medical Exam _____ b) Date of Last Biennial Flight review (BFR) _____

Insurance Information

6. a) Are you entitled to benefits under any accident or sickness insurance arranged by you or your employer? (including Loss of License, permanent health or Aircrew Disability Insurances) ☐ No ☐ Yes
If yes, please give details: _____

b) Are you covered under a state disability program? ☐ No ☐ Yes

7. Is this application for replacement of existing insurance? ☐ No ☐ Yes
If yes, please give full details of any pervious policy (i.e. Sum Insured, Name of Insurer, etc.): _____

8. **Have you ever:** a) engaged in hazardous sports or hobbies such as parachuting, auto or motorcycle racing? ☐ No ☐ Yes
b) had your driver's license suspended or revoked during the past three years? ☐ No ☐ Yes
If yes, please give details: _____

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 the application, shall form the basis of the insurance 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 the 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 in 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.

_____ Date

_____ Signature of Proposed Insured

_____ Signature of Applicant-Purchaser if not Proposed Insured

Pilot's Disability Insurance Application

Part 2

If **Yes** on any answers, please give **DATES** and **FULL DETAILS**

			No.	Details
9. Have you had investigated, diagnosed or been treated for:				
a) any psychiatric or nervous disorder (including migraine), epilepsy or any other form of convulsions or any loss of consciousness?	☐ **Yes**	☐ No		
b) any heart, blood pressure, circulatory or respiratory disorder?	☐ **Yes**	☐ No		
c) any condition involving eyes, nose, throat, alimentary tract, or genito-urinary system?	☐ **Yes**	☐ No		
d) any disorder of the blood or lymphatic systems?	☐ **Yes**	☐ No		
e) any condition affecting the bones and / or joints (including spinal conditions)?	☐ **Yes**	☐ No		
f) any disorders of the skin?	☐ **Yes**	☐ No		
g) diabetes?	☐ **Yes**	☐ No		
10. Have you ever been grounded or had your license invalidated for medical reasons?	☐ **Yes**	☐ No		
11. Has any limitations ever been endorsed on your license?	☐ **Yes**	☐ No		
12. After or during a medical examination:				
a) Have you ever been required to take additional test?	☐ **Yes**	☐ No		
b) Have you ever been referred to a specialist for an examination?	☐ **Yes**	☐ No		
c) Have you ever had the issue or renewal of your medical certificate deferred?	☐ **Yes**	☐ No		
d) Have you ever had to return for examination at less than the normal interval time?	☐ **Yes**	☐ No		
e) Have you ever been ordered to take drugs or follow any specific diet?	☐ **Yes**	☐ No		
13. Are you aware of any deterioration in your general health, hearing, eyesight or blood pressure?	☐ **Yes**	☐ No		
14. Has any insurance company or underwriter:				
a) declined or deferred an application from you?	☐ **Yes**	☐ No		
b) charged or quoted more than standard rates?	☐ **Yes**	☐ No		
c) cancelled or declined to renew your insurance?	☐ **Yes**	☐ No		
15. Are you taking medication?	☐ **Yes**	☐ No		

16. Please give the date of your last Electrocardiograph exam approved by the license issuing authority: _____

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 the application, shall form the basis of the insurance 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 the application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable.
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_____ Date

_____ Signature of Proposed Insured

_____ Signature of Applicant-Purchaser if not Proposed Insured

Pilot's Disability Insurance

Specified Occupation

This is a Specified Occupation Plan. It will terminate automatically if you change from the occupation in which you where engaged at the time the plan was issued, unless an agreement has been obtained in writing from the underwriters and any additional premium required by the underwriters has been paid. The sole liability of the underwriters in the event of an occupation change shall be returned on a pro-rata basis any unearned premiums paid for the balance of the plan term.

Exclusions

No benefits will be paid due to Sickness or Injury caused by, contributed to by or related to the following and / or their treatments and / or complications thereof:

1. Suicide or intentional self-inflicted injury or poisoning;
2. War, declared or undeclared (Please note that Terrorism or Acts of Terrorism is defined differently than war and is covered under this certificate);
3. An act of Terrorism involving the use or release of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s);
4. While committing or attempting to commit a crime;
5. Taking of illegal drugs, or addiction or misuse of prescription or non-prescription drugs;
6. Alcohol abuse or addition, or being under the influence or alcohol, as defined by the vehicle code of the state or province in which the Accident has occurred;
7. Mental or Nervous disorders;
8. Pre-Existing Conditions;
9. Subjective Pain or other symptoms unless supported by objective medical findings;
10. Pregnancy and pregnancy-related conditions including but not limited to fertility, pre-natal care, childbirth, miscarriage, abortion or postpartum conditions.

This brochure along with all of our other products and applications are available to download from our website
www.piu.org

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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