DENTISTS HIGH LIMIT

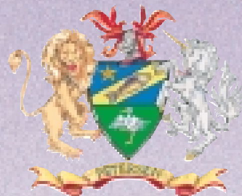
Disability Insurance

Personal Estate Plans

Income Replacement
Supplemental Disability
High Limit Disability

Business Estate Plans

Buy/Sell Agreements
Business Overhead Expense
Key Person
Contract Guarantee
Bank Loan Indemnification



PETERSEN INTERNATIONAL UNDERWRITERS
Lloyd's Correspondents
23929 Valencia Boulevard Suite 215 Valencia California 91355
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: ____________________

MONTHLY DISABILITY BENEFITS

Proposed Use of This Insurance:

❑ Personal Disability ❑ Buy-Sell ❑ Buy-In ❑ Buy-Out ❑ Overhead Expenses
❑ Key Person ❑ Contract Guarantee ❑ Bank Loan Indemnification

Monthly Disability Benefits will be paid while you are disabled beginning the first day following the Elimination Period and for as long as disabled, but not longer than the Benefit Period.

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

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

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

- **TOTAL DISABILITY**: Benefits will be paid to you when due to sickness or injury you no longer have the ability to perform in your regular occupation.
- **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:** Is a Total Disability benefits that will be paid for disability following surgery if 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.

- **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.
- **OPTIONAL COST OF LIVING ADJUSTMENT (COLA)** will annually automatically increase the monthly benefit amount based upon the Consumer Price Index (CPI), but not to exceed 10% per year.

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:

❏ Personal Disability ❏ Buy-Sell ❏ Buy-In ❏ Buy-Out
❏ Key Person ❏ Contract Guarantee ❏ Bank Loan Indemnification

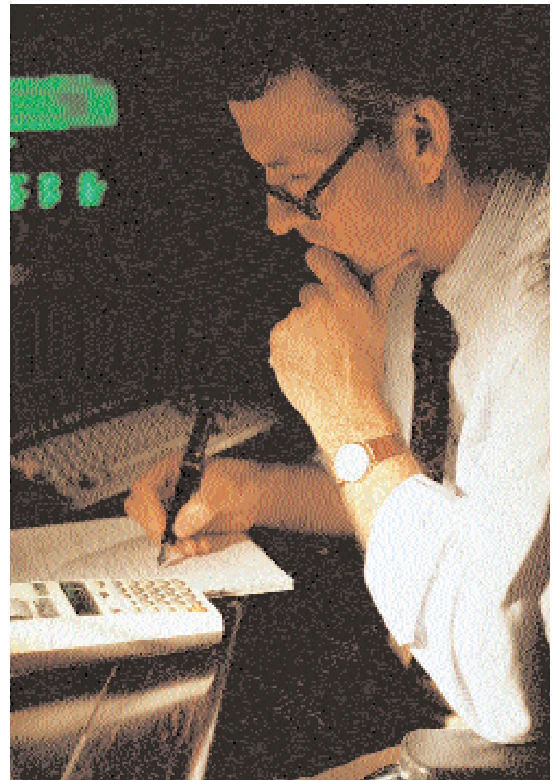
The Lump Sum Disability Benefit is payable as a result of a covered injury or sickness resulting in you becoming permanently and totally unable to perform in your regular occupation.

	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 ❏ ____________________

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



- You must have been totally disabled for the elimination period and at the end of such period you are determined by competent medical authority to be permanently totally disabled from your regular occupation.

- 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.

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The Certificate of Insurance is the complete description of coverage.

GENERAL INFORMATION

DEFINITIONS

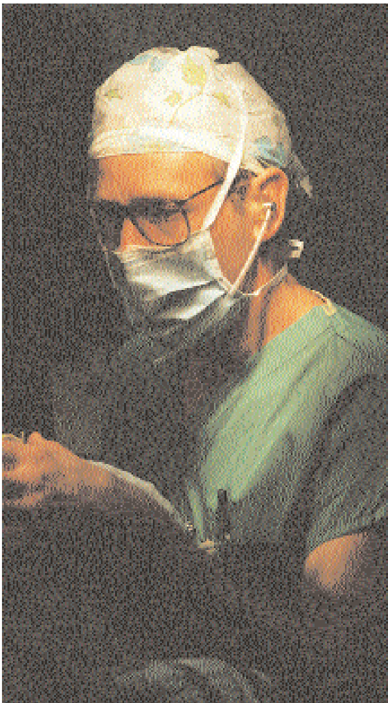
TERM OF INSURANCE is the time period during which the terms of the certificate or the rates charged cannot be changed by the Underwriters. On the renewal date following a Term of Insurance the underwriters reserve the right to refuse renewal or to offer renewal with different terms or rates.

THIS IS A DENTAL OCCUPATION certificate. The plan will automatically terminate if you change your occupation to something outside the dental profession after the certificate is 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 an 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.



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, or acts of terrorism 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.

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.).

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

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AUTHORIZATION TO RELEASE PERSONAL INFORMATION
HIPPA Compliant

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, 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 provide to Petersen International Underwriters, Inc., or to any agency authorized by Petersen International Underwriters, Inc to collect any and all such information by means of U.S. Post , fax or e-mail.

I AUTHORIZE Petersen International Underwriters to communicate with me/us or our representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, or additional coverages from Petersen International Underwriters.

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 those persons or organizations needing such information in 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 UNDERSTAND that I may revoke this Authorization, except to the extent that Petersen International Underwriters, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to Petersen International Underwriters Inc.. Any such revocation may also have an impact upon my Underwriting or claims processing.

I UNDERSTAND that I can obtain a complete copy of Petersen International Underwriters Inc. Privacy Policy either on Petersen International Underwriters, Inc. website or by contacting them directly and asking for a copy.

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 years from the date shown below.

Signed this ______________________________ day of ____________________ 20__________

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Signature of Proposed Insured