

RACERCOVER HIGH LIMIT INSURANCE

WORLD-WIDE COVERAGE



FOR

- *People in the Field of Professional Racing*
- *People Whose Avocation is Racing*

COVERING

- *Disability*
- *Accidental Death*
- *Major Medical*



PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondents

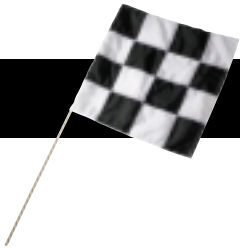
23929 Valencia Boulevard Suite 215 Valencia California 91355
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604
E-Mail: piu@piu.org Website: www.piu.org

PROPOSAL FOR: _____

AGE: _____ DATE: _____

OCCUPATION: _____

PRESENTED BY: _____



RACERCOVER HIGH LIMIT INSURANCE

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TOTAL DISABILITY BENEFITS

- **Weekly Benefits** are payable while totally disabled. Benefits begin the first day following the Deductible Elimination Period and pay for as long as the Benefit Period, for **each disability**.

Benefits are payable for: 1) Accident Only or Accident and Sickness
 2) 24-Hour Coverage or While Practicing and Racing Only

PERIOD OF INSURANCE _____	BENEFIT	ANNUAL PREMIUM
WEEKLY BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Days	
BENEFIT PERIOD, EACH DISABILITY	_____ Weeks	
MAXIMUM BENEFIT, EACH CLAIM	\$ _____	

PER RACE MISSED INDEMNITY BENEFITS

- **Per Race Missed Cash Indemnity** Amount is payable for each Scheduled Race missed because of being Totally Disabled during a benefit period.

Benefits are payable for 1) Accident Only or Accident and Sickness
 2) 24 Hour Coverage or While Practicing and Racing Only

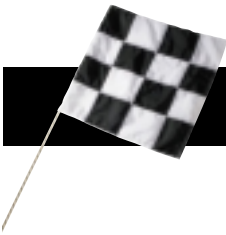
PERIOD OF INSURANCE _____	BENEFIT	ANNUAL PREMIUM
CASH INDEMNITY AMOUNT, EACH RACE	\$ _____	\$ _____
DEDUCTIBLE	# of _____ Races	
BENEFIT PERIOD, UP TO	# of _____ Races	
MAXIMUM BENEFIT, EACH CLAIM	\$ _____	

- **Total Disability** means that due to **sickness** or **injury** you cannot perform the material duties of your occupation.

SICKNESS MEANS disease or illness which is first diagnosed while this Certificate is in force and results in a disability within 365 days of the date of diagnosis.

INJURY MEANS accidental bodily injury sustained while the Certificate is in force and which results in disability within 365 days of the date of the accident.

*This is not intended to be a complete outline of coverage.
 Actual wording may change without notice. Proposal good for 30 days.*



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PERMANENT TOTAL DISABILITY BENEFITS

- **Permanent Total Disability Benefit** is payable after the specified number of months of Total Disability has elapsed and it is determined by competent medical authority that you have suffered a Career Ending Disability.

Benefits are payable for

1) Accident Only or Accident and Sickness

2) 24 Hour Coverage or While Practicing and Racing Only

PERIOD OF INSURANCE _____	BENEFIT	ANNUAL PREMIUM
LUMP SUM BENEFIT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Weeks	

PRINCIPAL SUM ACCIDENT BENEFITS

THE PRINCIPAL SUM AMOUNT \$ _____ ANNUAL PREMIUM \$ _____

- Accident Death 24 Hour Coverage or While Practicing and Racing Only
- Accident Death & Disbursement 24 Hour Coverage or While Practicing and Racing Only

PERIOD OF INSURANCE _____	BENEFIT	ANNUAL PREMIUM
ACCIDENTAL	DEATH	PRINCIPAL SUM
ACCIDENTAL DISMEMBERMENT BENEFITS	TWO LIMBS	PRINCIPAL SUM
	BOTH EYES	PRINCIPAL SUM
	ONE LIMB	ONE HALF PRINCIPAL SUM
	HEARING, BOTH EARS	ONE HALF PRINCIPAL SUM
	LOSS OF SPEECH	ONE HALF PRINCIPAL SUM

Optional Coverages: Acts of Terrorism or War, declared or undeclared

- Medical Expenses will be paid that exceed the Deductible Amount and the Co-Insurance Amount, up to the Maximum Benefit Amount for each injury or sickness.

Benefits are payable for

1) Accident Only or Accident and Sickness

2) 24 Hour Coverage or While Practicing and Racing Only

PERIOD OF INSURANCE _____	BENEFIT	ANNUAL PREMIUM
MAXIMUM BENEFIT AMOUNT	\$ _____	\$ _____
DEDUCTIBLE AMOUNT	\$ _____	

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SPECIFIED OCCUPATIONS

- These plans are Specific Occupation Plans. They will terminate automatically if you change from the occupation in which you were engaged in at the time the Plan was issued, unless 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 to return on a pro-rata basis any unearned premiums for the balance of the plan term.

CONDITIONS

■ **Total Disability and Missed Race Indemnity**

You must be under the regular care of a legally qualified physician for benefits to be payable. If in the opinion of the physician, future or continued treatment would be of no benefit to you, regular care shall not be required.

■ **Permanent Total Disability**

- 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 have suffered a Career Ending Disability to be eligible for the Lump Sum Benefit.
- 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 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.

■ **Medical Expenses**

- The Underwriters will pay necessary, usual and customary expenses for medical and surgical specialists' fees, hospital, nursing home and nursing attendance charges, cost of physiotherapy, massage and manipulative treatment, surgical and medical requisites, up to, but not exceeding the Maximum Benefit
- Covered expenses must be necessarily incurred and arise from illness manifesting itself or accidental bodily injury occurring during the Period of Insurance

- This is a brief and general description of the insurance provided by the plan. The Certificate of Insurance is the complete description of coverage. Market conditions change as to special coverages. A general description is appropriate, but the finite description is to be found in the certificate.

- This endorsement does not cover death caused or contributed to by: war, declared or undeclared, or acts of terrorism (unless such coverage is applied for and the appropriate additional premium has been paid); intentional self-inflicted death caused by sickness or injury suicide, committing or attempting to commit a felonious act; taking of illegal or non-prescribed drugs, or addiction or misuse of prescription drugs.

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

Website: <http://www.piu.org> E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE PERSONAL INFORMATION HIPAA 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_____

Signature of Proposed Insured