PETERSEN®
INTERNATIONAL UNDERWRITERS

Producer Number:_____

Loss of License Application

Loss of License means your temporary or permanent suspension by the Federal Aviation Administration (FAA).

Applicant's Name: First _____ M.I. _____ Last _____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ☐Male ☐Female

Citizenship: _____ Email: _____ Phone _____

Address: _____

City _____ State _____ Zip Code _____

Employer's Name: _____

Employer's Address: _____

City _____ State _____ Zip Code _____

Flying Occupation: _____ Non-Flying Occupation: _____

Annual Flying Income: US$_____ Annual Non-Flying Income: US$_____

Policy Owner: _____ Loss Payee: _____

(If other than Insured) *(If other than Insured)*

Owner Address: _____

City _____ State _____ Zip Code _____

Payment Mode: ☐ Monthly (EFT/CC) ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ In Full

Bill To: *(Please Select One)* ☐ Applicant's Address ☐ E-mail ☐ Owner's Address ☐ Employer - Attn.: _____

☐ Other: _____

Monthly Benefits *(if applicable)*			**Lump Sum Benefit** *(if applicable)*		
Monthly Benefit requested:	_____	US$	Principal Sum requested:	_____	US$
Elimination Period requested:	_____	Days	Elimination Period requested:	_____	Months
Benefit Period requested:	_____	Months			

Flight Categories: ☐ Corporate Pilot ☐ Commercial Pilot ☐ Cargo Pilot ☐ Firefighter Pilot ☐ Aerial Applicator ☐ Powerline Inspection ☐ Test Pilot ☐ Other: _____

Aircraft Categories: ☐ Fixed Wing ☐ Helicopter

FAA License: ☐ Class 1 ☐ Class 2

If "Yes" is answered for any of the following questions please provide full details in the space below.

1. Date of last Licensing Authority Medical Exam: _____
2. Expiration date of current medical authority certificate: _____
3. Date of last Flight Review: _____
4. Do you currently have any License or Medical Restrictions? ☐ Yes ☐ No
5. Is your current medical certificate issued as a Special Issuance? ☐ Yes ☐ No
6. Have you ever received a licensing authority denial or a deferral of your medical application? ☐ Yes ☐ No
7. Are you covered under a state disability program? ☐ Yes ☐ No
8. Is this application for replacement of existing insurance? ☐ Yes ☐ No
9. Have you ever engaged in hazardous sports or hobbies? ☐ Yes ☐ No
10. Have you ever had your drivers license suspended or revoked during the past three years? ☐ Yes ☐ No
11. 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 insurance? ☐ Yes ☐ No

_____

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If "Yes" is answered for any of the following questions please provide full details in the space below.

12. Have you had investigated, diagnosed, been treated for, any symptoms lasting longer than 1 month or recurring symptoms of :

a. any psychiatric or nervous disorder (including migraines), 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 the eyes, nose and/or throat?	☐ Yes ☐ No
d. any condition involving the gastrointestinal tract or the genitourinary tract?	☐ Yes ☐ No
e. any disorder of the blood or lymphatic system?	☐ Yes ☐ No
f. any condition affecting the bones and/or joints (including spine)?	☐ Yes ☐ No
g. any disorder of the skin?	☐ Yes ☐ No
h. diabetes?	☐ Yes ☐ No
i. any condition(s) not mentioned above?	☐ Yes ☐ No

13. After or during a medical examination, have you ever:

a. been required to take an additional test?	☐ Yes ☐ No
b. been referred to a specialist for examination?	☐ Yes ☐ No
c. had the issue or renewal of your medical certificate deferred?	☐ Yes ☐ No
d. had to return for examination at less than the normal interval time?	☐ Yes ☐ No
e. been ordered to take drugs or follow any specific diet?	☐ Yes ☐ No

14. Has any insurance company or underwriter:

a. declined or deferred an application you submitted?	☐ 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 aware of any deterioration in your health, hearing, eyesight or blood pressure? ☐ Yes ☐ No

16. Have you ever been grounded or had your license invalidated for medical reasons? ☐ Yes ☐ No

17. Have you ever had any limitations or endorsements on your license? ☐ Yes ☐ No

18. Are you currently taking any medications? ☐ Yes ☐ No

19. Date of your last electrocardiograph examination approved by the license issuing authority: _____

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

_____

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IT IS UNDERSTOOD AND AGREED

1) That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true, 2) That all answers on this application shall form the basis of the issuance of any coverage hereunder, 3) That in the event that You, the Loss Payee, the Owner or any person on Your behalf commits fraud, a misstatement or concealment either in the application or by any other statement, this Certificate may become void and no benefits will be payable, 4) That except as amended by the answers to the above questions, any answer shown on any prior application for this coverage signed and dated by me are expressly reaffirmed, 5) I have read or had read to me and understand each of the questions and statements on this entire application, and 6) No one has prevented me from spending as much time as I felt was necessary to understand this application.

_____ Date: _____
Signature of Applicant

_____ Date: _____
Signature of Policy Owner (if not Applicant)

Authorization to Release Personal Information

In Compliance with HIPAA & Financial Privacy Regulation

I, the proposed insured, authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/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 all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, HIV Tests/Test Results, and any other pertinent medical information.

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. Additionally, it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. 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.

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 that I have signed this Authorization.

Proposed Insured Name	Date of Birth
Last Four of Social Security Number	Email
Legal Representative*	Relationship

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

Signature of Proposed Insured _____ Date _____

Signature of Legal Representative (if other than Proposed Insured) _____ Date _____

PETERSEN®
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