PETERSEN® INTERNATIONAL UNDERWRITERS

ATHLETE RENEWAL APPLICATION

23929 Valencia Boulevard Second Floor, Valencia, CA 91355 | (800) 345-8816 | Fax (661) 254-0604 | piu@piu.org

1. Proposed Insured: First _____ Middle _____ Last _____

2. Team: _____

3. Have there been any changes to any of the information contained in your original application dated _____? ❑ Yes ❑ No

4. Have you consulted or been treated by a licensed physician, psychotherapist, psychologist, or other health care provider in the last 12 months, or from inception date of you current expiry coverage, whichever is longer? ❑ Yes ❑ No - If "Yes", please provide the following details:

Date	Description of Ailment	How Many Consecutive Games Were Missed as a Result of this Ailment

5. Do you have any reason to think that you may need to undergo a surgical operation in the future? ❑ Yes ❑ No

   If "Yes", please provide full details: _____

   _____

   _____

6. Do you have any other disability insurance with anyone other than Petersen International Underwriters? ❑ Yes ❑ No

Insurer	Date of Issue	Monthly Benefit	Lump Sum Benefit

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.

Signature of Applicant: _____ Date: _____

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 _____

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