SPORTS AND ENTERTAINMENT DIVISION

Professional Athletes Renewal Proposal Form

1) **Proposed Insured: FIRST ____________________________ MIDDLE_____________ LAST _____________________**

2) **Team: ____**

3) **Have there been any material 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 your current expiry coverage, whichever is longer?** ❒ **YES** ❒ **NO**

5) **If "YES", what was the date(s) of such: ________________________________**

6) **Please describe the ailment: ________________________________**

7) **How many consecutive games were missed as a result of this ailment? ________________**

8) **Have you any reason to think that you may need to undergo a surgical operation in the future?** ❒ **YES** ❒ **NO**

If "YES, please provide full details: ________________________________

____

9) **Are you presently applying for, have in force, or are applying to reinstate any disability insurance other than this application? (If YES, please list below)** ❒ **YES** ❒ **NO**

Insurer	Date of Issue	Monthly Benefit	Lump Sum Benefit

I hereby warrant that the answers given are complete, true and have been correctly recorded and I have not withheld any information which is calculated to influence the decision of the Underwriters.

Providing the answer to 4 above is, "NO", then Underwriters will not require a medical report and this Renewal Form will form part of the original Proposal and Contract.

The Underwriters do not bind themselves to accept renewal and reserve the right to impose specific exclusions as a result of information disclosed herein.

Authorization to obtain information:

To all physicians; medical professionals; hospitals; clinics; other health care providers; insurers; employers; Medical Information Bureau (MIB); consumer reporting agencies; other insurance support organizations; and other persons who have information about the Proposed Insured:

I authorize you to give the Company, its reinsurers, its agencies (a) all the information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the proposed insured; and (b) any Non-medical information, including an investigative consumer report, which the company believes it needs to perform the business functions described below.

The information obtained will be used to determine if the Proposed Insured is eligible for (a) the insurance requested; or (b) benefits under a policy which is in force. It will also be used for any other business purposes which relates to the insurance requested or the policy which is in force.

The form will be valid for 30 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

Signature of Applicant/Proposer: ________________________________ Date: ________________

PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondent

23929 Valencia Boulevard Suite 215 Valencia California 91355
Telephone (800) 345-88l6 (661) 254-0006 Facsimile (661) 254-0604

PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Boulevard, Suite 215, Valencia, California 91355
(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604
Website: http://www.piu.org E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured ____Date of Birth____________

I 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, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/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, information and/or 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. 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 refuse to sign this authorization and that such refusal to sign will not be a condition to affect the ability of the Applicant to obtain treatment. 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.

____ _________________
Signature of Proposed Insured/Patient Date

____ _________________
*Signature of Legal Representative (if other than Proposed Insured/Patient) Date

____
Printed Name and Relationship

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

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