

THE WORLDWIDE MAJOR MEDICAL PLAN

An International Major Medical Series Product



WORLDWIDE COVERAGE FOR

*People who work or reside
outside the United States
permanently or for
extended periods of time*

**New
All Cause
Deductible**



PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondents

23929 Valencia Boulevard Suite 215 Valencia California 91355-2186

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

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**Visit our website to download
our brochures and applications,
or to apply online.
www.piu.org**



THE WORLDWIDE MAJOR MEDICAL PLAN APPLICATION

To: PETERSEN INTERNATIONAL UNDERWRITERS

Lloyd's Correspondents

23929 Valencia Blvd., Suite 215 • Valencia, CA 91355-2186 • Tel (800) 345-8816 • Fax (661) 254-0604

To be eligible for this coverage, you must reside outside the United States for more than 5 months per year. Benefits may be assignable. Benefits are subject to all terms, limitations and conditions outlined in your certificate. **Please read your certificate carefully once you receive it.**

Plan Type:	<input type="checkbox"/> Excluding USA	<input type="checkbox"/> Including USA
Proposed Insured:	_____	
Non-U.S.A. Address:	_____	
U.S.A. Address:	_____	
Personal Information:	_____ (____) _____	DAYTIME PHONE NUMBER
Citizen of what country:	_____	_____
Occupation:	_____	_____
Last Medical Attendant:	_____	_____
Address:	_____	Date Last Seen: _____
Time outside U.S.A.:	(Months) _____	Deductible Requested: _____ Desired Effective Date: _____
Optional Benefits:	<input type="checkbox"/> War Coverage <input type="checkbox"/> Global Medical Transportation (Earliest effective date is 24 hrs. after Underwriting approval) <input type="checkbox"/> Hazardous Sports/Activities: Specify Sport(s) or Activities: _____	

Questions 1-22 must be answered to receive consideration for coverage. For any questions that you answer "YES," please provide details of the medical condition including treatment, dates, name address and phone number of attending physician, diagnosis, prognosis, and present course of treatment on a separate sheet. **Please attach these responses to this application.** The Underwriters may request additional medical information.

- 1) During the past 5 years, have you been diagnosed with any medical condition, received treatment (including medications or consultations), or been hospitalized for any medical, mental or nervous conditions? YES NO
 - 2) Are you currently disabled or unable to perform normal activities? YES NO
 - 3) Have you ever been declined or accepted on a modified term basis for life, disability or medical insurance? YES NO
 - 4) Have you ever received treatment or joined an organization for alcoholism or drug dependency? YES NO
 - 5) Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), Lymphadenopathy Syndrome, or any Immune System Disorder? YES NO
- Have you EVER been treated for, or have been told that, or have reason to believe that, you have any diseases, conditions, medical problems, disorders, sicknesses, or problems relating to any of the following:
- | | |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6) Heart? <input type="checkbox"/> YES <input type="checkbox"/> NO | 16) Bone, skeleton, muscles, joints or skin? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7) Blood Vessels or circulatory system? <input type="checkbox"/> YES <input type="checkbox"/> NO | 17) Allergy? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8) Blood Pressure? <input type="checkbox"/> YES <input type="checkbox"/> NO | 18) Epilepsy? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 9) Diabetes or glands? <input type="checkbox"/> YES <input type="checkbox"/> NO | 19) Genito-urinary system? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 10) Cancer, tumor, cyst, or growth? <input type="checkbox"/> YES <input type="checkbox"/> NO | 20) Reproductive system? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 11) Stomach, bowel or intestines? <input type="checkbox"/> YES <input type="checkbox"/> NO | 21) Have you ever been treated for or had any indication of physical disorder, injury or abnormality, not disclosed elsewhere on this application? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 12) Kidney, liver or gall bladder? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13) Lung or respiratory system? <input type="checkbox"/> YES <input type="checkbox"/> NO | 22) Have you ever applied to Lloyd's for Medical coverage in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 14) Sight or Hearing? <input type="checkbox"/> YES <input type="checkbox"/> NO | 23) Are you currently taking medication? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 15) Mental or nervous system? <input type="checkbox"/> YES <input type="checkbox"/> NO | Please provide reason taking and medication details |

****PLEASE REMEMBER TO ATTACH A SEPARATE SHEET WITH ALL DETAILS TO ANY YES ANSWERS ABOVE****
DECLARATION (Please Read Carefully)

I read and/or understand English. I have read the above statements. I declare that the above information is true and complete to the best of my knowledge and belief. Apart from the matters disclosed above, I am in good health and ordinarily enjoy good health. In the event of fraud, misstatements, concealment, or failure to disclose information on this application, whether intentional or inadvertent, any insurance issued based upon this application may become void and no benefits will be payable.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health, to give to the Petersen International Underwriters.

Date: _____
Signature of Proposed Insured _____



THE WORLDWIDE MAJOR MEDICAL PLAN

To be Eligible for Benefits, you must reside outside the United States for more than 5 months per year.

THE WORLDWIDE MAJOR MEDICAL PLAN WORKS LIKE THIS:

- Deductibles:** You may choose a \$500, \$1,000, \$2,500, or \$5,000 per person, per period of insurance.
- Coinsurance:** After the Deductible is paid, Underwriters will reimburse 80% of the next \$5,000 in Eligible Expenses and then 100% up to the Maximum Benefit.
- Maximum Benefit:** \$5,000,000 per person per lifetime (Ages 0 through 69)
- Maximum Benefit:** \$500,000 per person per lifetime (Ages 70 through 74)

LIMITED BENEFITS AVAILABLE FOR:

- MATERNITY
- MENTAL AND NERVOUS CONDITIONS

ELIGIBLE EXPENSES

Treatment may be received anywhere in the world excluding the U.S.A. or for an additional premium the U.S.A. may be covered as well. This coverage is secondary to medical benefits, services, or reimbursements from any other source except Medicaid. Underwriters will reimburse the Eligible Expenses incurred, listed below, when Medically Necessary for the diagnosis and treatment of an Illness or Injury, subject to the terms and limitations described in the Certificate.

- Hospital room and board (limited to the semi-private daily rate).
- Hospital intensive care unit.
- Other Medically Necessary Hospital services and supplies, such as emergency room care, outpatient surgery, diagnostic services, supplies and therapy.
- Skilled Nursing Facility room and board, if confinement begins within 30 days following a Medically Necessary Hospital confinement of three days or longer.
- Home Health Care, if hospitalization would have been required if Home Health Care were not provided, and the care is provided in accordance with a written plan established and approved by a Physician.
- Local area ambulance service.



- Physician services consisting of home, office, and hospital visits, and any other medical care and treatment.
- Diagnostic services, supplies, and therapy.
- Outpatient medications prescribed by a treating physician following any hospitalization.

RENEWAL AGREEMENT

This coverage is conditionally renewable based upon residency requirements and payment of premium. Underwriters reserve the right to modify coverage by class.

10 Day Free Look

If, for any reason, you are not satisfied with the insurance described in the Certificate you have the right to return the Certificate within 10 days of its delivery to you and your premium will be fully refunded.

This is not intended to be a complete outline of coverage. Actual wording may change without notice.



THE WORLDWIDE MAJOR MEDICAL PLAN

OPTIONAL COVERAGES

Hazardous Sports or Activities

If you elect this option, Underwriters will reimburse you for eligible expenses which are incurred due to an injury resulting from the participation in a Hazardous Sport or Activity that is specifically named on the Schedule of Benefits.

War or Act of War Coverage

If you elect this option, underwriters will reimburse you for eligible expenses which are incurred as a result of injuries sustained due to war or act of war.

Global Medical Transportation

If you elect this option, underwriters will reimburse you for all medically necessary expenses for stabilization and transportation to the facility nearest your home, which can provide the appropriate care.

LIMITATIONS

Expenses which have limitations are as follows:

- 1) Maternity, normal delivery and/or well baby care covered after 15 months, to a maximum of \$5,000 per year. Complications of pregnancy covered as any other condition after 15 months.
- 2) Mental and Nervous Disorders covered to \$5,000 lifetime maximum for outpatient visits. Disorders necessitating hospitalization shall be covered as any other condition.

EXCLUSIONS

Expenses which are not eligible for reimbursement are as follows:

- Any expense which you are not legally obligated to pay.
- Services which are not Medically Necessary and are not furnished by or under supervision of a Physician.
- Expenses for services and supplies for which you are entitled to benefits, services, or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan, or from any other source, except Medicaid.
- Expenses in excess of Usual, Customary, and Reasonable fees.
- Outpatient drugs, except following a hospitalization if prescribed for the same illness or injury.
- Self-inflicted injuries while sane or insane.
- Treatment for alcoholism, drug addiction, and/or allergies.
- Rest cures, quarantine, or isolation.
- Cosmetic surgery, unless necessitated by an accidental injury.
- Dental exams, dental x-rays, and general dental care except as a result of an accidental injury.
- Eye glasses or eye examinations.
- Hearing aids or hearing examinations.
- General or routine examinations.
- Injuries sustained from participation in hazardous sports or activities which in part include: Professional or recreational: mountaineering, snow skiing, scuba diving, hang gliding, skydiving, bungee jumping, racing of any kind, and all professional and semiprofessional sports.
- Pregnancy and pregnancy-related conditions including, but not limited to, fertility, pre-natal care, childbirth, miscarriage, or abortion until a minimum of 15 months has elapsed, subject to the Terms and Limitations in the Certificate.
- Injuries due to war or any act of war whether declared or undeclared. Terrorism however is included in the policy benefits.
- Injuries sustained while committing a criminal or felonious act.
- Expenses incurred for, or resulting from, pain which is not supported by medical diagnosis.
- Cataract surgery which is not considered an emergency and/or which is performed at Your discretion.
- Any elective surgery.
- Custodial Care.
- Pre-existing conditions not disclosed on the application.

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THE WORLDWIDE MAJOR MEDICAL PLAN

THE WORLDWIDE MAJOR MEDICAL PLAN RATES

(Excluding Coverage in U.S.A.)

To include U.S.A. coverage all premiums to be multiplied by 2

ANNUAL PREMIUMS

AGE	\$500 DEDUCTIBLE		\$1,000 DEDUCTIBLE		\$2,500 DEDUCTIBLE		\$5,000 DEDUCTIBLE	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
0-9*	162.50	162.50	125.00	125.00	112.50	112.50	100.00	100.00
10-17*	175.50	175.00	137.50	137.50	125.00	125.00	112.50	112.50
18-24	425.00	737.00	325.00	500.00	287.50	450.00	225.00	362.50
25-29	475.00	812.50	362.00	575.00	312.50	500.00	250.00	400.00
30-34	500.00	900.00	375.00	650.00	325.00	575.00	262.50	462.50
35-39	550.00	937.50	425.00	725.00	362.50	625.00	287.50	500.00
40-44	612.50	775.00	462.50	575.00	400.00	500.00	325.00	412.50
45-49	687.50	850.00	525.00	650.00	450.00	575.00	362.50	425.00
50-54	837.50	937.50	625.00	700.00	575.00	650.00	462.50	512.50
55-59	1,025.00	1,025.00	787.50	787.50	687.50	687.50	562.50	562.50
60-64	1,362.50	1,287.50	1,112.50	1,000.00	1,000.00	937.50	800.00	712.50
65-69	2,650.00	2,275.00	2,175.00	1,825.00	1,725.00	1,500.00	1,375.00	1,200.00
70	N/A	N/A	2,700.00	2,300.00	2,000.00	1,700.00	1,600.00	1,362.50
71	N/A	N/A	2,825.00	2,425.00	2,175.00	1,837.50	1,700.00	1,470.00
72	N/A	N/A	2,975.00	2,550.00	2,350.00	2,000.00	1,880.00	1,600.00
73	N/A	N/A	3,125.00	2,700.00	2,525.00	2,187.50	2,020.00	1,750.00
74	N/A	N/A	3,300.00	2,825.00	2,750.00	2,400.00	2,200.00	1,925.00

*If applying with an adult, otherwise use 18-24 rates

UNDERWRITING NOTES

One application per person. A family will be added onto one certificate. A photocopy of the application is acceptable.

Please do not send money with the application. The earliest effective date is 24 hours after approval, or the requested effective date (up to 30 days following the approval of the application).

HOW TO CALCULATE

- 1) Use actual age.
- 2) Add up all insureds.
- 3) Multiply by 2 if U.S.A. coverage is required.
- 4) Add optional hazardous sports/activities.
- 5) Add \$100 processing fee.
- 6) Global Medical Transportation - 30% rate
- 7) War or Act of War Coverage - please call

OPTIONAL HAZARDOUS SPORTS/ACTIVITIES BENEFITS

Recreational Scuba	add 10% or \$80 whichever is greater
Recreational Snow Skiing	add 10% or \$80 whichever is greater
All other Hazardous Sports/Activities	Call Petersen International Underwriters

This is not intended to be a complete outline of coverage. Actual wording and premiums may change without notice.

Underwriters reserve the right to modify terms and benefits at time of underwriting



THE WORLDWIDE MAJOR MEDICAL PLAN

An International Major Medical Series Product

The Worldwide Major Medical Plan

Because the World is Dynamic—Not Stationary!

Why The Worldwide Major Medical Plan?

The Worldwide Major Medical Plan began in development several years ago.

Traditional medical insurance assumes that the insured never ventures far away from a managed care facility. Having a population remain in one place is the only way a managed care program can function. This still remains true and is an important part of health insurance in the United States. Most carriers, and even countries with socialized healthcare access, often are not capable of claims administration on an international basis.

However, traditional medical plans and even the supplemental travel medical plans became limited with a new type of individual needing medical insurance — The global citizen!

Many U.S. citizens have found themselves residing outside the United States either permanently or for an unknown period of time. These people need medical coverage in the country in which they are residing, but also may desire coverage that if something serious happened, they could use the coverage for treatment in the United States. These same people also may travel to other locations necessitating a portable international medical plan.

The Worldwide Major Medical Plan provides valuable benefits in any country in which a person is located and even may provide benefits available for treatment back in the United States.



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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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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