Disclaimer

PETERSEN® INTERNATIONAL UNDERWRITERS

Insurance can be effective only after the underwriting department receives and reviews your application. The earliest effective date will be the next day after the review.

Underwriting department is open from Monday through Friday, 7 AM to 4 PM, Pacific Time, excluding holidays.

By submitting this paper application, you acknowledge and agree that:

- Back dated applications are not possible.
- Requested effective date is not always guaranteed.
- It does not matter when you send the application by postal mail, fax or scanned copy in email.
- It does not matter when the postal mail, fax or email was received by us, as the underwriting department can consider the effective date only according to when they review the application.
- If there is any dispute between you and the underwriting department about when the effective date should be, the decision of the underwriting department will be final.
- You hold Insubuy and the writing agent (if any) harmless and relieve us from any liability because of this.

If the above terms are not acceptable to you, please do not submit the application.

If you need to purchase the insurance urgently with a specific effective date, please call our office at +1 (866) INSUBUY or the writing agent to confirm, before sending the application.

Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093 | Phone: (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

PETERSEN INTERNATIONAL UNDERWRITERS

Coverholder at Lloyd's of London

Domestic and International Disability - Medical - Life - Contingency Insurance Coverages

Bridge Plan Attestations

As stated in the Petersen marketing bulletin, dated 12/28/2018, a Bridge Plan application submitted to Petersen International Underwriters on or after 1/1/2019 requires two additional attestations.

To be eligible for the Bridge Plan coverage, you must attest to the following statements:

- ☐ I attest that I am not eligible for Medicare or Affordable Care Act (PPACA) compliant insurance.

- ☐ I attest that I have tried, but was unable to obtain short-term medical insurance.

  Reason _____

I understand and agree that all statements above, to the best of my knowledge and belief, are complete and true.

Insured's Signature_____ Date_____

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The Bridge Plan Application Form

Producer Number: 25735

To be eligible for the Bridge Plan coverage, you must attest to the following statements:

- ❑ I attest that I am not eligible for Medicare or Affordable Care Act (PPACA) compliant insurance.
- ❑ I attest that I have tried, but was unable to obtain short-term medical insurance. Reason _____

Applicant's Name: First _____ Middle _____ Last _____

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

Residence Address: _____

City _____ State _____ Zip Code _____

E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____

Requested Start Date: _____ Date you expect to be eligible for Medicare: _____

Plan Type: ❑ **Platinum** *($1,000,000 Max. & $1,000 Deductible)* ❑ **Gold** *($500,000 Max. & $2,500 Deductible)*
❑ **Silver** *($250,000 Max. & $5,000 Deductible)* ❑ **Bronze** *($100,000 Max. & $10,000 Deductible)*

Coverage Type: ❑ Bridge Part A & B ❑ Bridge Part A Only ❑ Bridge Part B Only

Last healthcare provider seen:
a. Doctors Name & Address: _____
b. Date and reason last seen: _____
c. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided below or attach a separate page if needed

1. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ❑ Yes ❑ No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
3. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ❑ Yes ❑ No
4. Have you ever been evaluated or treated for any injury, condition or disorder involving the following? ❑ Yes ❑ No

a.	Eyes/Ears	❑ Yes ❑ No	o.	Back/spine/neck	❑ Yes ❑ No
b.	Gout	❑ Yes ❑ No	p.	Throat/Thyroid/Glands	❑ Yes ❑ No
c.	Skin	❑ Yes ❑ No	q.	Bones/Bone Density	❑ Yes ❑ No
d.	Hernia	❑ Yes ❑ No	r.	Arthritis/Joints (Hips Knees, Shoulders)	❑ Yes ❑ No
e.	Diabetes	❑ Yes ❑ No	s.	Fainting/Dizziness/Unconsciousness	❑ Yes ❑ No
f.	HIV/AIDS	❑ Yes ❑ No	t.	Fatigue/Tiredness/Paralysis/Weakness	❑ Yes ❑ No
g.	Sleep apnea	❑ Yes ❑ No	u.	Nervous System/Alzheimer's/Dementia	❑ Yes ❑ No
h.	Gallbladder	❑ Yes ❑ No	v.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
i.	Concussions	❑ Yes ❑ No	w.	Respiratory System/Asthma	❑ Yes ❑ No
j.	Chronic Pain	❑ Yes ❑ No	x.	Circulatory system	❑ Yes ❑ No
k.	Lymph nodes	❑ Yes ❑ No	y.	Reproductive system	❑ Yes ❑ No
l.	Cancer/Growth	❑ Yes ❑ No	z.	Gastrointestinal System	❑ Yes ❑ No
m.	High blood pressure	❑ Yes ❑ No	aa.	Urinary system/Prostate	❑ Yes ❑ No
n.	Heart/Chest Pain/Stroke	❑ Yes ❑ No	ab.	Any other condition not listed above	❑ Yes ❑ No

5. Has your weight changed in the past year? ❑ Yes ❑ No
6. Have you ever undergone a surgical operation? ❑ Yes ❑ No
7. Have you taken any medicines in the past 12 months? ❑ Yes ❑ No
8. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed? ❑ Yes ❑ No
9. Other than the medical conditions noted on this application, I am in good health. ❑ Yes ❑ No
10. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

DECLARATION

I declare that the above statements are true and complete. I am in good health and ordinarily enjoy good health. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that this is a temporary insurance policy designed to cover the insured person for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product. I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured _____ Signature _____ Date _____
Please Print

Payment Authorization Form

Insubuy, Inc,
4200 Mapleshade Ln, Suite 200, Plano, TX 75093
Fax: (972) 767-4470

❍ Pre-Authorized Monthly $_____

Insured's Name		
Account Billing Address		
City	State	Zip
Email		Phone

Option 1) Credit Card - VISA MasterCard AMERICAN EXPRESS DISCOVER NETWORK

Card #

Expiration Date: /

Security Code:

Name on Card:

Option 2) Electronic Check - **(Must be a U.S. Bank Account)**

Select Account Type:

☐ **Checking**

☐ **Saving**

Routing # *(9-digits)*

Account #

Name on Account

Please Include a Copy of a Voided Check

I understand that this authorization will remain in effect until Petersen International Underwriters receives a written request from me to cancel my automatic withdrawal at least 3 days prior to the next scheduled withdrawal or until Petersen International Underwriters elects to cancel this agreement. I understand that if two or more deductions are not honored, Petersen International Underwriters has the right to discontinue my enrollment in the Electronic Funds Transfer Payment Plan. I hereby authorize Petersen International Underwriters to debit my account for the correct installment premium on the due dates of the installments. I understand that my coverage is not in effect until all requirements have been submitted and approved by Petersen International Underwriters. I acknowledge that the origination of EFT transactions to my account must comply with the provision of U.S. law.

Signature: _____ **Date**: _____

Monthly Premium Rates

Age	Platinum $1,000,000 Maximum Benefit $1,000 Deductible	Gold $500,000 Maximum Benefit $2,500 Deductible	Silver $250,000 Maximum Benefit $5,000 Deductible	Bronze $100,000 Maximum Benefit $10,000 Deductible
60	$698	$470	$311	$235
61	$701	$485	$329	$250
62	$706	$500	$347	$265
63	$709	$513	$366	$281
64	$712	$528	$384	$296
65	$717	$543	$404	$311
66	$720	$558	$422	$326
67	$723	$572	$440	$343
68	$726	$587	$459	$358
69	$731	$602	$477	$373
70	-	$617	$495	$389
71	-	$632	$515	$406
72	-	$647	$533	$421
73	-	$662	$551	$436
74	-	$675	$570	$451
75	-	$690	$588	$467
76	-	$705	$608	$482
77	-	$720	$626	$497
78	-	$734	$644	$512
79	-	$749	$663	$529
80	-	-	-	$646
81	-	-	-	$667
82	-	-	-	$686
83	-	-	-	$705
84	-	-	-	$724
85	-	-	-	$745
86	-	-	-	$764
87	-	-	-	$783
88	-	-	-	$804
89	-	-	-	$823
90+	Contact Our Office For Options.			

Additional Calculations:

- For Part A coverage only = above rates x .60
- For Part B coverage only = above rates x .60