

# INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE

Offered Exclusively by:  
eGlobalHealth Insurers Agency, LLC  
Broker # 26356  
Derek Patterson, Broker/Agent  
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Direct: 417-882-1413  
Fax: 417-459-4623



## **FOR**

*U.S. Dollar Term Life Insurance for use when there is an international insurable interest involved.*

## **USES**

*Employees of Foreign National Firms  
International Asset Protection  
International Business Travel  
Short Term Needs  
Special Assignments*



## **PETERSEN INTERNATIONAL UNDERWRITERS**

*Lloyd's Correspondents*

23929 Valencia Boulevard Suite 215 Valencia California 91355  
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604  
E-Mail: [piu@piu.org](mailto:piu@piu.org) Website: [www.piu.org](http://www.piu.org)

PROPOSAL FOR: \_\_\_\_\_

DATE: \_\_\_\_\_

PRESENTED BY: \_\_\_\_\_

# INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE

PROPOSAL FOR: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ SMOKER: \_\_\_\_\_ DATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

POLICY PERIOD: A) \_\_\_\_\_ B) \_\_\_\_\_ C) \_\_\_\_\_

FACE AMOUNT: A) \$ \_\_\_\_\_ B) \$ \_\_\_\_\_ C) \$ \_\_\_\_\_

ANNUAL PREMIUM: A) \$ \_\_\_\_\_ B) \$ \_\_\_\_\_ C) \$ \_\_\_\_\_

UNDERWRITING REQUIREMENTS:  Application  Exam  Blood & Urine  EKG  Financial Justification  
 Other \_\_\_\_\_

## POLICY FEATURES

### Policy Periods

International Term life Insurance is available for time periods from 1 month up to a maximum of 10 years, on a level premium basis. During the policy period requalifying is not required and the premiums are payable on an annual basis.

### Issue Ages

From ages one year to seventy-five years.

### How to Obtain a Rate Indication

**Geographical Limitations:** Most policies are written for world-wide coverage. There are certain areas in the world where restrictions or limitations may apply. It is important to obtain as much information regarding travel and place of residency as possible. Be specific on city and country.

**Financial Justification:** Whether the insurance is for business use or personal use, financial justification is critical to successful underwriting. Please be sure there is adequate justification for the amount to be insured.

**Occupations:** Before assigning a premium to a risk the determination of the insured's occupational duties and the amount of travel related to their work assists us in developing accurate rates.

**Avocation:** Please advise as to any hazardous sports or recreational activities in which the proposed insured may be involved.

**Purpose of Coverage:** Developing a clear picture as to the importance of this insurance aids the underwriters in developing the best possible rates.

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



# INTERNATIONAL TERM LIFE INSURANCE APPLICATION

Please Return To:

**eGlobalHealth Insurers Agency, LLC**

**info@GlobalRiskBroker.com Direct: 417-882-1413 Fax: 417-459-4623**

*Underwritten by Certain Underwriters at Lloyd's of London*

**Proposed Insured:**

NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

**Residence Address:**

NUMBER & STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE/COUNTRY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**Reason for Insurance:**

\_\_\_\_\_

**Profession or Occupation:**

\_\_\_\_\_ AVERAGE ANNUAL INCOME \_\_\_\_\_

**Personal Statistics:**

DATE OF BIRTH \_\_\_\_\_ AGE NEXT BIRTHDAY \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

**Name of Beneficiary:**

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**Name of 2ND Beneficiary:**

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**Usual Medical Attendant:**

NAME AND ADDRESS \_\_\_\_\_

**NOTE CAREFULLY:** Failure to disclose all material facts could render the contract void. Material facts are those which an assurer would regard as likely to influence the assessment and acceptance of an application for assurance. If you are in any doubt as to whether certain facts are material, such facts should be disclosed.

DEATH BENEFIT \$ \_\_\_\_\_

TERM PERIOD: \_\_\_\_\_ YEARS

**HAVE YOU EVER HAD:** (please check appropriate boxes)

1. Asthma, bronchitis, pleurisy, tuberculosis or any disease of the lungs? . . . . .  YES  NO
2. Rheumatic Fever, chest pain, blood pressure or any heart trouble or abnormality? . . . . .  YES  NO
3. Indigestion, ulcer, colitis, bladder, kidney, prostate or digestive trouble? . . . . .  YES  NO
4. Diabetes, thyroid, rheumatism, gout or liver complaint? . . . . .  YES  NO
5. Depression, anxiety, breakdown, blackout, faints, fits or any mental or nervous disorder? . . . . .  YES  NO
6. Any other ailment, impairment, injury or need for special attention? . . . . .  YES  NO
7. Any tests, operations, x-rays or special investigations? . . . . .  YES  NO
8. Any special diet or treatment, including tablets or drugs? . . . . .  YES  NO
9. Counseling or medical advice in connection with AIDS or any sexually transmitted disease? . . . . .  YES  NO
10. An AIDS blood test? . . . . .  YES  NO
11. Have you consulted any doctor in the last five years? . . . . .  YES  NO
12. Have you smoked any form of tobacco in the last twelve months? . . . . .  YES  NO

If so, please state consumption. \_\_\_\_\_

***If any of the above is answered "YES" please give details on next page.***

# INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE

Question No.	Illness, Details and Treatment	Dates and Duration	Doctors, Hospitals, Clinics, etc.
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Are any of your parents, brothers or sisters dead? If so, please give cause and age at death. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Give particulars of any likely travel outside your country of residence. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you any intention of flying (other than as a passenger on recognized airlines), or engaging in any hazardous pursuits such as diving, mountaineering or racing of any kind? If so, give details. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has a proposal on your life ever been declined, deferred or accepted on special terms? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you effected or applied for cover on your life with any other insurer within the last two years, or is it your intention to do so in the foreseeable future? If so, when and to which insurer? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## DECLARATION

I, the Life to be Assured, declare that to the best of my knowledge and belief all statements made hereon are true and complete. I consent to the Underwriters seeking medical information from any insurance office to which a proposal has been made for assurance on my life and I authorize the giving of such information.

I/We proposing to effect the assurance agree that the answers are true and complete to the best on my/our knowledge and belief in the terms of the policy to be issued in respect of this proposal shall be dependent upon the answers given and the statements made in this proposal and made by the Life to be Assured to any medical examiner appointed by the Underwriter.

SIGNATURE OF PROPOSED INSURED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF OWNER \_\_\_\_\_ DATE \_\_\_\_\_

*(If other than insured)*

FULL NAME AND ADDRESS \_\_\_\_\_

*(only required if the owner is other than the Life to be Insured)*

# INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE

## Term Life Insurance Assignment of Benefits

I wish to assign the benefit of the policy for which I am applying in this application to the following person(s). If more than one beneficiary is named, please state the proportion of the sum assured that is to be received by each beneficiary.

<u>Name</u>	<u>Relationship</u>	<u>Share of Sum Assured</u>
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

(Insured)

# 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](mailto:piu@piu.org)

## **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*

# **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](mailto:piu@piu.org)