



PROFESSIONAL ATHLETES APPLICATION

SHORT FORM

eGlobalHealth Insurers Agency, LLC

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

Name in Full: _____
FIRST MIDDLE LAST

Residence Address: _____
STREET AND NUMBER
CITY STATE ZIP () DAYTIME PHONE NUMBER

Personal information: _____
DATE OF BIRTH HEIGHT WEIGHT

Occupation Details: _____
SPORT LEAGUE
TEAM POSITION

Earnings: _____
(last year) OCCUPATIONAL WINNINGS/EARNINGS ENDORSEMENT INCOME

COVERAGE APPLYING FOR:

<input type="checkbox"/> PTD (Permanent Total Disability)	<input type="checkbox"/> TTD (Temporary Total Disability)
Benefit Requested: \$ _____	Monthly Benefit Requested: \$ _____
	Benefit Period Requested: _____
	Elimination Period Requested: _____ days

QUESTIONNAIRE

- Are you currently free of injury and illness and playing for your sport? YES NO
- Have you during the last 24 months missed any playing time due to injury or illness? YES NO
If so, enter dates, reason(s) and total number of games missed.

- Have you any reason to think that you may need to undergo a surgical operation and/or medical treatment in the future? YES NO
Give details _____
- Do you engage in any other sport(s) and/or activities other than the sport which is your primary occupation? YES NO
Please give dates and for what reasons.

- Are you taking or have you taken any medication in the past 2 years? YES NO
Please give dates and for what reasons

- Have you any physical defect or infirmity? Give details. YES NO

- Is your sight in any way impaired; have you ever suffered from any disease of the eyes? Give details. YES NO

- Is your hearing impaired; have you ever had any discharge from the ears? Give details. YES NO

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9) Have you ever suffered from Appendicitis, Asthma, Blood Pressure Abnormalities, Blood-spitting, Diabetes, Dyspepsia, Fits, Gout, Hernia, Paralysis, Piles, Rheumatism, or any Rheumatic infection, Skin Infections, Varicose Veins, or any Diseases or Disorders of the Chest or Respiratory System, Heart, Stomach, Bladder or Nervous System? Give dates and state if operation performed. YES NO

10) Do you have any hardware remaining (such as pins, screws, rods, plates, etc.)? YES NO
 Details _____

11) Have you during the past 5 years had any other operation or suffered from any other illness or accident? If so, give details and dates. YES NO

12) Have you consulted a doctor during the past 2 years? Please give dates, for what reasons, and what were the results. YES NO

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

Insurer	Date of issue	Monthly Benefit	Lump Sum Benefit

14) Have you ever made any claim for accident or illness? YES NO
 If yes, please state each case as to nature of claim, date, amount and name of company or underwriter.

15) Have you ever been declined, or accepted on special terms, for life insurance or insurance against accident or illness? YES NO

16) Has any company or underwriter ever cancelled or declined to renew your policy? Give details. YES NO

17) Do you engage in any sport(s) as a professional other than the sport, which is your prime occupation? If so give details. YES NO

18) Are you now and have you been perfectly well and in sound health for a year preceding this application? YES NO

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 RELEASE SUCH DOCUMENTATION TO PETERSEN INTERNATIONAL UNDERWRITERS.

DECLARATION

I hereby warrant that all the answers and statements herein contained are full, complete and true and have been correctly recorded and I have not withheld any information which is likely to influence the decision of the underwriter and that I am willing to accept a policy, subject to the terms and conditions of such policy, to be issued on the basis of and in consideration of the proposal.

The insurance applied for will not take effect unless the health of the Proposed Insured remains as stated in the Application on the inception date of the policy. Underwriters do not bind themselves to accept this application for insurance, and reserve the right to decline and/or impose specific exclusions as a result of information disclosed herein.

PROPOSED INSURED _____ DATE _____

SIGNATURE OF APPLICANT _____



PROFESSIONAL ATHLETES MEDICAL EXAM

MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: _____

7) Doctor to examine Proposed Insured. If exam results were not normal, please describe in detail.
If more space is required, attach a separate sheet.

	Exam Results		
	NORMAL	ABNORMAL	
a) HEAD (including concussion or unconsciousness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) NECK (Cervical Spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) RIGHT SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) LEFT SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) CHEST (Including Ribs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
f) UPPER BACK (Thoracic Spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
g) LOWER BACK (Lumbar Spine including Coccyx and tail bone)	<input type="checkbox"/>	<input type="checkbox"/>	_____
h) PELVIS/HIPS (including groin-specify side)	<input type="checkbox"/>	<input type="checkbox"/>	_____
i) ABDOMEN (including stomach)	<input type="checkbox"/>	<input type="checkbox"/>	_____
j) RIGHT ARM (including elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____
k) LEFT ARM (including elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____
l) RIGHT HAND (including wrist, fingers and thumb)	<input type="checkbox"/>	<input type="checkbox"/>	_____
m) LEFT HAND (including wrist, fingers and thumb)	<input type="checkbox"/>	<input type="checkbox"/>	_____
n) RIGHT THIGH (including hamstring)	<input type="checkbox"/>	<input type="checkbox"/>	_____
o) LEFT THIGH (including hamstring)	<input type="checkbox"/>	<input type="checkbox"/>	_____
p) RIGHT KNEE	<input type="checkbox"/>	<input type="checkbox"/>	_____
q) LEFT KNEE	<input type="checkbox"/>	<input type="checkbox"/>	_____
r) RIGHT LOWER LEG (including ankle and Achilles tendon)	<input type="checkbox"/>	<input type="checkbox"/>	_____
s) LEFT LOWER LEG (including ankle and Achilles tendon)	<input type="checkbox"/>	<input type="checkbox"/>	_____
t) RIGHT FOOT	<input type="checkbox"/>	<input type="checkbox"/>	_____
u) LEFT FOOT	<input type="checkbox"/>	<input type="checkbox"/>	_____



PROFESSIONAL ATHLETES MEDICAL EXAM

MEDICAL DOCTOR'S REPORT FORM

Proposed Insured: _____

8) Height: _____ 9) Weight: _____

10) Blood Pressure _____ 11) Pulse: _____

12) Please check the appropriate boxes

	Normal	Abnormal	Comments
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, Ears, Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____

13) Current medication(s) and reason(s) taken _____

14) On completion of physical examination, overall impression with regard to player's ability to continue their career.

15) As a Physician, please state your relationship to the proposed insured, i.e., Personal Physician, Team Physician, etc?

I certify that I made this examination at _____ a.m. p.m. on the _____ day of _____, 20 _____.

Examination made at my office individual's office individual's home other _____

PHYSICIAN'S SIGNATURE

PHYSICIAN'S FULL NAME (PLEASE PRINT)

PHYSICIAN'S ADDRESS

APPLICANT'S SIGNATURE

APPLICANT'S FULL NAME (PLEASE PRINT)

EXAMINER'S TELEPHONE

EXAMINER'S FAX

PETERSEN INTERNATIONAL UNDERWRITERS, INC.

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

Website: <http://www.piu.org> E-Mail: 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, Inc. 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, Inc.

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

Name 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