

# PRO JOCKEY DISABILITY INSURANCE

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



*FOR*  
*Professional Horse Racing*  
*Jockeys, Drivers or Trainers*

*FEATURING*  
*Worldwide 24-hr. Coverage*  
*Accident and Sickness Coverages*

*USES*  
*Loss of Future Earnings*  
*Contract Completion*  
*College to Pro Protection*  
*Loss of Endorsements*  
*Costs of Agents/Managers*

*OPTIONAL*  
*Loss of Image/Endorsement*  
*Coverage Available*



**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: \_\_\_\_\_

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

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

# PRO JOCKEY DISABILITY INSURANCE

## PROFESSIONAL ATHLETES MONTHLY DISABILITY BENEFITS

**Purpose:**  Personal Disability  Contract Guarantee  Loss of Image/Endorsement

**Monthly Benefits** will be paid to the Insured when Totally Disabled. Total Disability means the Insured's complete and total physical inability to participate in his/her regular occupation. Benefits will begin on the first day following the Elimination Period and pay for each month or portion of a month during the total disability of the Insured, but not for longer than the Maximum Benefit Period.

POLICY PERIOD _____	<input type="checkbox"/> 24 hour Coverage	<input type="checkbox"/> Other _____
	<b>BENEFIT</b>	<b>PREMIUM</b>
MONTHLY BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Days	
MAXIMUM BENEFIT PERIOD	_____ Months	
MAXIMUM BENEFIT	\$ _____	

**SUBJECT TO SATISFACTORY:**  Short Form Application/Exam  Financial Justification of Sum to be Insured

## INSURING AGREEMENT

If injury or sickness results in the **Total Disability** of the Insured, and such Total Disability commences during the Policy Period and within six (6) months of the date of the accident causing bodily injury, or in the event of sickness within six (6) months of the date such sickness first manifests itself, the Underwriters will pay to the Insured the Monthly Benefit Amount, during the period of Total Disability, but not beyond the maximum benefit period.

## SPECIAL FEATURES

### RECOVERY, RECURRENT AND SUBSEQUENT DISABILITY:

If the Insured returns to work after a period of Total Disability for which benefits were received, and is able to perform the duties of the insured's occupation, a Total Disability commencing thereafter will be subject to a new Elimination Period. If the Insured suffers a recurrence of Total Disability during the Policy Period as a result of the same Accidental Bodily Injury, Sickness, or Disease, such recurrence will be deemed part of the prior disability for the purposes of satisfying the Elimination Period.

With regard to any such recurrent or subsequent disability of the insured, the Underwriters will pay the Monthly Benefit only for the unused portion of the Maximum Benefit Period not previously exhausted by payment of Monthly Benefits due to any prior disability or disabilities.

No benefits are payable in the event of participation, or attempted participation in the Insured's occupation, after commencement of Total Disability, unless first approved by a sports medicine Physician.

No benefits are payable if the services in the Insured's occupation are terminated, or altered, to decrease compensation and/or the period of the contract, unless the Insurer is notified, and agrees in writing to continue the coverage in force. If the Insured engages in an occupation, or activity of greater risk without obtaining the Insurer's permission in writing, and paying any required additional premium, no claim is payable.

War, attempted suicide or self-destruction, or intentionally self-inflicted injury, the Insured's own criminal or felonious act; deaths being under the influence of alcohol, as defined by the vehicle laws of the state in which the accident occurred; being under the influence of drugs or narcotics that are not lawfully available, unless prescribed for the Insured by a qualified health care practitioner; using drugs or substances in violation of the rules or regulation of the governing body of the sport in which the Insured participates; conditions of Psychotic, Psychoneurotic or Epileptic origin, the operation, learning to operate, or serving as a member of a crew of an aircraft.

*This is a brief description of the insurance provided by this plan.  
The Certificate of Insurance is the complete description of coverage.*

# PRO JOCKEY DISABILITY INSURANCE

## PROFESSIONAL ATHLETES CAREER ENDING DISABILITY

**Purpose:**  Personal Disability  Contract Guarantee  Loss of Image/Endorsement

The **Capital Sum** is payable after the specified elimination period. The Capital Sum Benefit may be taken in a single lump sum benefit, or in monthly Benefit Amounts as an annuity of the lump sum.

POLICY PERIOD _____	<input type="checkbox"/> 24 hour Coverage	<input type="checkbox"/> Other _____
	<b>BENEFIT</b>	<b>PREMIUM</b>
CAPITAL SUM BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD _____	Months	

SUBJECT TO SATISFACTORY:  Short Form Application/Exam  Financial Justification of Sum to be Insured

## CAPITAL SUM

Eligibility for the Capital Sum Benefit is conditional upon the Insured having been Totally Disabled for the entire Elimination Period and is then determined by competent medical authority to be Permanently Totally Disabled. Total Disability must result from a bodily injury caused by an accident occurring while this Certificate is in force and results in disablement within 365 days from the date of the accident, or sickness that first manifests itself while this Certificate is in force and results in disablement within 365 days from the date of such manifestation.

## SPECIAL FEATURES

- **This is not an integrated policy!** This benefit is payable, **in addition to and not reduced by**, any other disability benefits provided by this or any other plan.
- The **Capital Sum Benefit** may be taken in a **single lump sum benefit or** designed to **PAY LONG-TERM MONTHLY BENEFITS** as an annuity of the lump sum amount.

Payment of the Capital Sum Benefit must be approved by two independent referees; one a legally qualified physician or surgeon, and the other an independent expert of recognized standing in the occupation of the Insured person. If the two referees fail to agree that the Insured person is permanently and totally disabled they will appoint an umpire to decide the matter. These decisions will be final and binding on the Insured and the Underwriters.

War, attempted suicide or self-destruction, or intentionally self-inflicted injury, the Insured's own criminal or felonious act; deaths being under the influence of alcohol, as defined by the vehicle laws of the state in which the accident occurred; being under the influence of drugs or narcotics that are not lawfully available, unless prescribed for the Insured by a qualified health care practitioner; using drugs or substances in violation of the rules or regulation of the governing body of the sport in which the Insured participates; conditions of Psychotic, Psychoneurotic or Epileptic origin, the operation, learning to operate, or serving as a member of a crew of an aircraft.

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# PRO JOCKEY DISABILITY INSURANCE

## SPECIFIED OCCUPATIONS

This plan is a Specified Occupation Plan. It will terminate automatically if the Insured changes from the occupation in which he/she was engaged at the time the Plan was issued, unless an agreement has been obtained in writing from the underwriters, and any additional premium required by the underwriters has been paid. The sole liability of the underwriters in the event of an occupation change shall be to return any unearned premiums paid for the balance of the Plan term.

## TERM OF COVERAGE

This Plan is annually renewable, or for negotiated longer periods of time. It is contemplated that the Plan will be renewed, however, the underwriters reserve the right to refuse to renew or to change the premium rate on renewal. A renewal application, or a statement of good health may be required by the underwriters for consideration of renewal.

## OPTIONAL PLANS OR PLAN DESIGNS

These plans are used in a number of ways to insure the professional athlete either personally or to insure third parties with whom the athlete is affiliated, as to the financial losses that result from a disabling accidental bodily injury, or sickness. Career length varies by the individual athlete. Exceptionally high earnings are often generated in a short time span making the adequate insuring of the earning potential a primary financial planning process. Here are some of the uses of these plans:

### ■ **Loss of Future Earnings**

A professional athlete can anticipate income levels and probable playing time. A disability can affect the level of income to be earned in the future, and a disability can shorten the career period. As an example, an athlete has no income assurance beyond the term period of the present contract. This plan can insure an income should disability shorten the expected career period.

### ■ **Contract Completion**

The loss of an athlete by disability puts the owner in double jeopardy . Revenue may slip, and the owner must continue to pay the non-performing athlete. These plans can insure the contracted compensation to the athlete, thus relieving the owner of that financial burden.

### ■ **Loss of Image/Endorsements**

Endorsement income, and fees, continue to flow as long as the public remains fans of the athlete. A political statement, a drug involvement, a drunk arrest, a public relations goof, and the advertiser/endorsers pull back from sponsorship. This loss is also insurable.

### ■ **Cost of Agents/Managers**

During periods of disability it is in the athletes best interest to continue the use of agents and managers to sustain the athlete's value as an athlete, and as a product spokesperson, keenly in the minds of those who contract for their services. These costs can be insured.

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# PETERSEN INTERNATIONAL UNDERWRITERS, INC.

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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, 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](mailto:piu@piu.org)