

STARCOVER 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
People in the
Entertainment Industry

INCLUDING
Actors • Directors • Producers
Writers • Cinematographers
Art Directors • Editors
Musicians • Singers • Dancers
Stunt Persons • Special Effects
Models • Make-Up Artists
and others

ALSO AVAILABLE FROM
PETERSEN INTERNATIONAL
Event Cancellation
Kidnap & Ransom
Jewelry & Collections



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 Website: www.piu.org

PROPOSAL FOR: _____

AGE: _____ DATE: _____

OCCUPATION: _____

PRESENTED BY: _____



MONTHLY DISABILITY BENEFITS

- Personal Disability
 Buy-Sell
 Buy-In
 Overhead Expenses
 Key Person
 Contract Guarantee
 Bank Loan Indemnification

Monthly Benefits are payable while Totally Disabled or Residually Disabled, if applicable, beginning the first day following the Elimination Period and for as long as the Benefit Period **for each disability**.

	BENEFIT	ANNUAL PREMIUM
MONTHLY BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Days	
BENEFIT PERIOD	_____ Months	
MAXIMUM BENEFIT EACH CLAIM	\$ _____	
TERM OF INSURANCE	_____ Year(s)	
OPTIONAL RESIDUAL DISABILITY RIDER		\$ _____
OPTIONAL COLA RIDER (CPI) 10%		\$ _____
TOTAL ANNUAL PREMIUM		\$ _____

UNDERWRITING REQUIREMENTS: Application Medical Exam Blood Urine EKG _____

SPECIAL FEATURES

- **TOTAL DISABILITY** means that due to **sickness or injury you cannot perform the material duties of your regular occupation**. You must be under the regular care of a legally qualified physician.
- **PRESUMPTIVE DISABILITY** benefits will be paid for the maximum benefit period **even if you are able to return to any occupation**. Benefits will be paid should you **lose the use of** both hands, both feet, one hand and one foot, the sight in both eyes, hearing in both ears, or the ability to speak. The medical care requirements and the elimination period will be automatically waived.
- **RECURRENT DISABILITIES** resulting from the same cause or causes are considered a **new claim** with a **new benefit period** if you have returned to your regular occupation, full-time, for six months or longer.
- **TRANSPLANT BENEFIT** means that Total Disability benefits will be paid for disability following surgery **if you donate an organ from your body** to another person. Benefits will be paid as a sickness benefit. This benefit is applicable after the certificate has been in force for six months or longer.
- **RESIDUAL DISABILITY** means that you are engaged in your occupation and **your income is reduced** due to a disability by 20% or more. The benefit will be calculated by multiplying the monthly benefit by the percentage of reduced income compared to the average income from the preceding twelve months at the time of disability.
- **COST OF LIVING ADJUSTMENT (COLA)** will **automatically increase** the monthly benefit amount based upon the Consumer Price Index (CPI), but not to exceed 10% per year.

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



LUMP SUM DISABILITY BENEFITS

- Personal Disability
- Buy-Sell
- Buy-In
- Key Person
- Contract Guarantee
- Bank Loan Indemnification

The Principal Sum is payable after the specified elimination period.

	BENEFIT	ANNUAL PREMIUM
BENEFIT AMOUNT	\$ _____	\$ _____
ELIMINATION PERIOD	_____ Months	
TERM OF INSURANCE	_____ Year(s)	

UNDERWRITING REQUIREMENTS: Application Medical Exam Blood Urine EKG _____

SPECIAL FEATURES

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

CONDITIONS

- You must have been totally disabled for the elimination period and at the end of such period you are determined by competent medical authority to be unable to resume the material duties of your regular occupation and that you have suffered a career-ending disability.
- We reserve the right to have you examined by a physician of our choice. Should your physician and our physician not be able to agree that you are permanently totally disabled, your physician and our physician shall name a third physician to make a decision on the matter which shall be final and binding.
- Disability must result from an injury or sickness which is first diagnosed or incurred and which results in a loss beginning while the certificate is in force.
- This is a **pure own-occupation disability insurance plan**. The plan will automatically terminate if you change your occupation after the certificate is issued, unless you get written acceptance from the Underwriters to agree to cover you in the new occupation.

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



GENERAL INFORMATION

DEFINITIONS

Sickness means disease or illness which is first diagnosed and results in a disability while this Certificate is in force.

Injury means accidental bodily injury sustained and which results in a disability while the Certificate is in force.

SPECIFIED OCCUPATIONS

These plans are Specified Occupation Plans. They will terminate automatically if you change from the occupation in which you were engaged in 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 on a pro-rata basis any unearned premiums paid for the balance of the plan term.

TERM OF INSURANCE

These plans are annually renewable or for longer periods of time up to three (3) years in duration or up to five (5) years for contract completion covers. It is contemplated that the plans will be renewed, however, the underwriters reserve the right to refuse to renew or to change the premium rates on renewal. A statement of good health may be required by the underwriters for consideration of renewal.

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the plan shall continue in force.

Non-renewal by the Insurer will be without prejudice to any claim in connection with a loss commencing while this plan is in force.

This policy does not cover any loss resulting from pregnancy, maternity, suicide or attempted suicide, intentionally self-inflicted injuries while sane or insane, alcoholism, drug addiction, mental or nervous disorders, subjective pain unless supported by objective medical findings as to the cause of the pain, the commission or attempted commission of a criminal or felonious act or serving in the military service of any country except for service in the military reserve of the United States.

War, declared or undeclared, riot or civil insurrection are not covered unless an additional premium has been paid to provide such coverage and the underwriters have accepted this extended risk.

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

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

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

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