GROUP INTERNATIONAL MAJOR MEDICAL PLANS

An International Major Medical Series Plan

GIC Insurance Agency
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FOR

Foreign Nationals while Visiting the U.S.A.

U.S.A. Citizens Residing or Traveling outside the U.S.A.

Foreign Nationals who reside outside the U.S.A. and who work for a U.S.A. Firm

USES

Business Assignments

Pleasure

Educational Pursuits

Religious Activities

PLANS AVAILABLE FOR

Short Term

Multiple Trips

Long Term

PETERSEN INTERNATIONAL UNDERWRITERS
Lloyd's Correspondents
23929 Valencia Boulevard Suite 215 Valencia California 91355-2186
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604
E-Mail: piu@piu.org Website: www.piu.org

PROPOSAL REQUEST/APPLICATION

Please Return To:

PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Blvd., Suite 215 • Valencia, CA 91355 • Tel (800) 345-8816
Underwritten by Certain Underwriters at Lloyd's

PART I. General

Full Name of Company or Group: ______________________________

Type of Company: ______________________________

Address: ______________________________

Contact Person: ____________________ Title: ____________________

Phone: ______________ Fax: ______________ E-Mail: ______________

Target Effective Date: ______________ Is coverage to be: On-going? ❑ or Fixed time period? ❑

If fixed, length of cover needed: ______________________________

Does this group have current coverage or had prior coverage? YES ❑ NO ❑

If Yes please indicate for at least past three years: Name of Carrier: ______________________________

Reason for changing: ______________________________ Please attach Loss data as detailed as possible

Full-Time People: Total in Group: ______________ Total to be covered under this plan: ______________

Part-time People: Total in Group: ______________ Total to be covered under this plan: ______________

Number of people to be covered by age band: Under 30 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60-64 ____ 65+ ____

Should this proposal include an option for dependents? YES ❑ NO ❑

Should this proposal include cover in the USA? YES ❑ NO ❑

A census of the group to be covered, including names, addresses, and dates of birth will be needed during final underwriting.

Will this be: ❑ Voluntary or ❑ Non-voluntary

If you could design your own plan, what benefits would you include?:

Deductible: $ ________ Co-insurance: ________ Maximum benefit: $ ________ Target Monthly Premium: $ ________

Other Requests?: ______________________________

Other Thoughts or Comments?: ______________________________

Rate and plan design guarantees, premium billings, and addition of new employees are subject to change from group to group. These items will be provided with a proposal. Contract disputes are required to go before binding arbitration. If you already have a proposal, please attach a copy of the plan desired for final underwriting approval. Once received, this application and information shall be reviewed and full market support will be sought. Coverage cannot be bound until there is 100% market support. Completion of this Proposal/Application does not constitute an offer or acceptance.

Signature of Company/Group Representative: ______________________ **Date:** __________

Printed Name and Title: ______________________________

GROUP INTERNATIONAL MAJOR MEDICAL PLANS

The following is a description of a standard basic plan design. Alternative designs are available on a case by case basis. Each plan is designed to best fit the size and needs of the group. In some cases, provisions of the following description may be enhanced or deleted.

DESCRIPTION OF TYPICAL BENEFITS

DEDUCTIBLE	COINSURANCE	MAXIMUM BENEFIT
Choice of **$100, $250, $500, $1,000, $2,500 or Higher** per illness or injury	After the deductible Underwriters will reimburse **80%** of next $5,000 in eligible expenses and **then 100%** up to the Maximum Benefit	**$25,000 - $5,000,000**

Eligible expenses caused by an illness or injury and incurred from any doctor or any hospital within a specified geographical area will be reimbursed to you. Benefits may be assignable directly to the providers once a Claim Review has been completed.

ELIGIBLE EXPENSES

Hospital Expenses including:

Semi-private room and board, intensive care, other medically necessary hospital services and supplies, such as emergency room care, outpatient surgery, diagnostic services, supplies and therapy.

Physician Services Consisting of:

Home, office, and hospital visits, diagnostic services, supplies and therapy.

Skilled Nursing Facility including:

Room and board, provided confinement begins within 30 days following a medically necessary hospital confinement of three days or longer.

Home Health Care:

If hospitalization would have been required if Home Health Care were not provided, and the Home health Care is provided in accordance with a written plan established and approved by a physician.

Ambulance Services:

To and from a hospital in the geographic area.

Prescription Drugs:

Covered during and following a period of hospitalization.

Repatriation of Remains:

In the case of death, underwriters will reimburse the costs of delivery of your remains to a mortuary near your home.

Common Accident Provision:

In the event that you and any additional insured family members suffer injuries from the same accident, only one deductible and coinsurance shall be applied.

Global Medical Transportation Coverage:

Underwriters will reimburse you for the costs of medically necessary transportation to return you to the facility nearest your home which can provide appropriate care, up to $100,000.

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

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The following is a description of a standard basic plan design.
Alternative designs are available on a case by case basis.

LIMITATIONS

Expenses which have limitations are as follows: .

1) The maximum Eligible Expense for room and board charges is $450 per day.
2) The maximum Eligible Expense room and board charge for an intensive care unit is three times the Provider's semi-private room and board charge or $1350 per day whichever is the least.
3) Insured age 70-74 are limited to $250,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.
4) Insured age 75-79 are limited to $100,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.
5) Insured age 80-84 are limited to $50,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.

A Preexisting Condition will not be covered until the insurance described in this certificate has been in effect for a period of 12 months. A preexisting condition is one in which an insured sought medical attention or was advised to seek medical attention during the 12 month period preceding the effective date of the policy.

Expenses which are not eligible for reimbursement are as follows:

1) Any expense which You are not legally obligated to pay.
2) Services which are not Medically Necessary or are not furnished by and under supervision of a Physician .
3) Expenses for services and supplies for which You are entitled to benefits, services or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan or from any other source except Medicaid.
4) Expenses in excess of UCR.
5) Outpatient drugs, except following a hospitalization if prescribed for the same Illness or Injury.
6) Self-inflicted injuries while sane or insane.
7) Treatment for alcoholism, drug addiction, allergies
8) Mental or nervous disorders.
9) Rest cures, quarantine or isolation.
10) Cosmetic surgery unless necessitated by an injury.
11) Dental exams, dental x-rays and general dental care except as a result of an injury.
12) Eye glasses or eye examinations.
13) Hearing aids or hearing examinations.
14) General or routine examinations.
15) Injuries sustained from participation in Hazardous Sports or Activities
16) Pregnancy and pregnancy-related conditions including but not limited to fertility, pre-natal care, childbirth, miscarriage, abortion or postpartum conditions.
17) Injuries or illnesses due to war or any act of war whether declared or undeclared.
18) Injuries or illnesses sustained while committing a criminal or felonious act.
19) Expenses incurred for or resulting from pain which is not supported by medical diagnosis.
20) Cataract surgery
21) Any elective surgery.
22) Custodial Care.
23) Expenses for supplies and services that were not incurred within the specified Geographic Area.
24) Pre-existing conditions.

This is not intended to be a complete outline of coverage. Actual wording may change without notice.
Underwriters reserve the right to modify terms and benefits at time of underwriting.

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.).

Right to access or correct your personal information

You have a right to request access to or correction of your personal information in our possession.

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

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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