

INTERNATIONAL AND SPECIAL USE TERM LIFE INSURANCE

GIC Insurance Agency ☐
P.O. Box 291 ☐
Fair Grove, Mo. 65648 ☐
Phone: (417) 759-2009 ☐
Fax: (417) 459-4870 ☐
website: info@gicinsurance.org ☐
e-mail: info@gicinsurance.org



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 Website: www.piu.org

PROPOSAL FOR: _____

DATE: _____

PRESENTED BY: _____
Jeff Wood ☐
Agent# 19917

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.



INTERNATIONAL TERM LIFE INSURANCE 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 of London

- Proposed Insured:**
- Residence Address:**
- Reason for Insurance:**
- Profession or Occupation:**
- Personal Statistics:**
- Name of Beneficiary:**
- Name of 2ND Beneficiary:**
- Usual Medical Attendant:**

NAME _____ MIDDLE _____ LAST _____

NUMBER & STREET _____

CITY _____ STATE/COUNTRY _____ ZIP CODE _____

_____ AVERAGE ANNUAL INCOME _____

DATE OF BIRTH _____ AGE NEXT BIRTHDAY _____ PLACE OF BIRTH _____

HEIGHT _____ WEIGHT _____ MARITAL STATUS _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

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.

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

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www.gicinsurance.org/ agent#19917, Phone: (417) 759-2009, Fax: (417) 459-4870, email: info@gicinsurance.org

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)

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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

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