

Entertainment Disability Insurance

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 Many More



Petersen
International Underwriters
Lloyd's Coverholder

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Telephone 800.345.8816
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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 Certificate does not cover sickness or injury caused by or contributed to by war (declared or undeclared), intentional self-inflicted injury or while committing a criminal or felonious act. Subjective pain in and of itself will not be considered as a disabling event, unless supported by objective medical findings of physiological abnormality, trauma, disease, infection or viral invasion as a cause thereof. Claims arising from drugs, alcohol, mental and nervous disorders are excluded from this insurance plan.

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The Certificate of Insurance is the complete description of coverage.*



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 HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

I, _____ hereby acknowledge this Authorization to Release Health
(Proposed Insured/Patient)
Related information.

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment which includes, but is not limited to:

- Physicians
- Hospitals
- Clinics
- Medically related facilities
- Rehabilitation facilities
- Laboratories
- Other/Specific: _____

____ Proposed Insured/Patient Initials

to disclose my medical records to Petersen International Underwriters (or its assigned representative including, but not limited to: Secure Image Solutions) for the purpose of insurance underwriting or claims administration. For purposes of this authorization, medical records shall include, but not be limited to:

- Patient Histories
- Progress notes
- Test results
- X-rays
- Psychiatric Evaluations
- Drug and/or Alcohol Treatment information
- HIV Test Results and/or
- Other diagnostic information

____ Proposed Insured/Patient Initials

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured/Patient

Date

Printed Name

Signature (if by someone other than the Proposed Insured/Patient)

Date

Printed Name and Relationship

I, _____ understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters
23929 Valencia Boulevard, Suite 215
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization.

This Authorization will expire 2 years after the date the Authorization is signed unless a different date is specified here: _____.

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured/Patient

Date

Printed Name

Signature (if by someone other than the Proposed Insured/Patient)

Date

Printed Name and Relationship

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