Petersen International Underwriters
23929 Valencia Blvd., Suite 215
Valencia, CA 91355
(661)254-0006 / (800)345-8816
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International Risk Management Group
4414 Route 202
Doylestown, PA 18902
(215)794-1488 / (888)622-4764
FAX (215)794-1498

INSURED'S STATEMENT

DETAILS OUTLINING PROOF OF LOSS FOR DISABILITY INSURANCE

Please show all policy numbers: _____ _____ _____ _____

Name of Insured: _____ Telephone #: _____

Social Security #: _____Age: _____ Date of Birth: ____/____/____Height: _____ Weight: _____

Physical Address: _____

Mailing Address (if different): _____

Employer: _____ Occupation: _____

Employer's Address: _____

List ALL material duties which account for the majority of your income within your occupation:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

List ALL substantial duties which account for most of your work time within your occupation:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

List ANY OTHER duties which are required in your occupation, not listed above, but have significance:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Please identify ALL duties which you are prevented from performing during this period of disability:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Please list ALL OTHER medical and disability policies, include company name and policy numbers:

Insurer Policy
Insurer Policy
Insurer Policy
Insurer Policy

AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or 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 give to International Risk Management Group any and all such information.

I UNDERSTAND the purpose of this Authorization is to allow International Risk Management Group to determine eligibility for life or health insurance benefits under a life or health policy. Any information obtained will not be released by International Risk Management Group, to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organization performing business or legal services in connection with my policy, 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 AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and a half years from the date shown below.

Signature: _____ Signed this _____ day of _____, 20_____

Nature of Employment (Tasks & Duties): _____

Last Date of Work:

Between what dates were you TOTALLY disabled?
From To

Between what dates were you PARTIALLY disabled?
From To

On what date did you resume part of your duties?

Is this claim covered by Worker's Compensation or other occupational disability coverage? YES NO

ABOUT YOUR DISABILITY

Accident
Injury: _____
Describe Circumstances Surrounding Injury _____
_____
Date of Injury: _____ Location: _____
Date First Consulted Physician: _____
Hospitalized (if YES, include hospital and dates of hospitalization)? _____

Sickness
Describe Sickness: _____
Date First Noticed Sickness: _____ Date First Consulted Physician: _____
Hospitalized (if YES, include hospital and dates of hospitalization)?_____
Were you ever sick with this condition before? _____

Name and Address of PRIMARY attending physician for this disability: _____
_____

Name and Address of ALL physicians who attended you for this disability:

Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____

Name and Address of ALL physicians seen during the past five (5) years:

Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____

Were you ever admitted to a hospital before? List reasons and dates: _____
_____

I declare under penalty of perjury that the above information is true and correct.

_____ _____
Signature Date