



PILOT DISABILITY INSURANCE APPLICATION

Producer Name	Producer #
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PERSONAL INFORMATION

First	Middle	Last	
Place of Birth	Date of Birth	Height	Weight
Residence Street Address			
City	State	Zip Code	
Telephone	Fax	Email	
Policy Owner		Loss Payee	
Employer			
Flying Occupation		Non-Flying Occupation	
Flying Income		Non-Flying Income	

PREMIUM & BENEFIT

Bill To: <input type="radio"/> Email <input type="radio"/> Residence <input type="radio"/> Employer <input type="radio"/> Other: _____	Premium Mode: <input type="radio"/> Multi-Year Prepay <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly (CC/EFT)	Monthly Benefit Amount (if applicable): \$ _____ Elimination Period (days): <input type="radio"/> 30 <input type="radio"/> 60 <input type="radio"/> 90 <input type="radio"/> 180 <input type="radio"/> 365 Benefit Period (months): <input type="radio"/> 12 <input type="radio"/> 24 <input type="radio"/> 36 <input type="radio"/> 48 <input type="radio"/> 60 Optional Coverage: <input type="checkbox"/> Residual <input type="checkbox"/> COLA
		Lump Sum Benefit Amount (if applicable): \$ _____ Elimination Period (months): _____

FLYING INFORMATION

Flight Categories: <input type="checkbox"/> Corporate Pilot <input type="checkbox"/> Commercial Pilot <input type="checkbox"/> Cargo Pilot <input type="checkbox"/> Firefighter Pilot <input type="checkbox"/> Aerial Applicator <input type="checkbox"/> Powerline Inspection <input type="checkbox"/> Test Pilot <input type="checkbox"/> Other: _____
Aircraft Categories: <input type="checkbox"/> Fixed Wing <input type="checkbox"/> Helicopter
Current Licenses: <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> Instrument Flight Rating <input type="checkbox"/> Rotorcraft <input type="checkbox"/> Multi-Engine <input type="checkbox"/> Airline Transport Rating

INSURANCE INFORMATION

1. Date of last FAA Medical Exam: _____	Any Medical Restrictions:	<input type="radio"/> Yes <input type="radio"/> No
Details: _____		
2. Date of last Biennial Flight Review: _____	Any License Restrictions:	<input type="radio"/> Yes <input type="radio"/> No
NoDetails: _____		
3. Are you covered under a state disability program?		<input type="radio"/> Yes <input type="radio"/> No
NoDetails: _____		
4. Is this application for replacment of existing insurance?		<input type="radio"/> Yes <input type="radio"/> No
Details: _____		
5. Have you ever engaged in hazardous sports or hobbies?		<input type="radio"/> Yes <input type="radio"/> No
Details: _____		
6. Have you ever had your drivers license suspended or revoked during the past three years?		<input type="radio"/> Yes <input type="radio"/> No
Details: _____		
7. Are you entitled to benefits under any accident or sickness insurance arranged by you or your employer including loss of license, permanent health or aircrew disability insurance?		<input type="radio"/> Yes <input type="radio"/> No
Details: _____		

PETERSEN
INTERNATIONAL UNDERWRITERS

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application.

(Please Intitial)

