

PILOT DISABILITY INSURANCE APPLICATION

Producer Name Producer #									
Personal Inform	ATION								
First		Middle		Last					
Place of Birth Date of Bir		of Birth		Height			Weight		
Residence Street Address									
City State			Zip Code						
Telephone Fax				Email					
Policy Owner				Loss Payee					
Employer									
Flying Occupation				Non-Flying Occup	ation				
Flying Income				Non-Flying Income					
Premium & Benef	IT								
Bill To:					able): \$_				
O Email	OMulti-Ye	OMulti-Year Prepay		ion Period (days)			Q 90	O 180	O 365
O Residence	OAnnual			Period (months):			Q 36	Q 48	O 60
O Employer	○Semi-An	OSemi-Annual		Coverage:	☐ Resi	dual		A	
Other:	Q uarterl	uarterly		ım Benefit Amou	nt (if apr	olicable):	\$		
o dilei.		(1.1 (CC/PPT)		Elimination Period (months):					
FLYING INFORMATI	ION		1						
	rporate Pilot	☐ Comme	rcial Pilot	☐ Cargo Pilot	☐ Fire	fighter P	ilot 🗆	Aerial Au	plicator
	Flight Categories: Corporate Pilot Commercial Pilot Cargo Pilot Firefighter Pilot Aerial Applic Powerline Inspection Other:								
Aircraft Categories: ☐ Fix	ed Wing	☐ Helicopt	er						
Current Licenses: ☐ Flight Instructor ☐ Commercial ☐ Intsrument Flight Rating ☐ Rotorcraft						t			
☐ Multi-Engine ☐ Airline Transport Rating									
INCUDANCE INCODA	MATION								
Insurance Information 1. Date of last FAA Medical Exam: Any Medical Reference Any Medical Ref					·•			O Yes	O No
Details:									
2. Date of last Biennial Flight Review: Any License NoDetails:								O Yes	O No
3. Are you covered under a state disability program? NoDetails:							O Yes	O No	
4. Is this application for replacment of existing insurance? Details:							O Yes	O No	
5. Have you ever engaged in hazardous sports or hobbies? Details:							O Yes	O No	
6. Have you ever had your drivers license suspended or revoked during the past three years? Details:							O Yes	O No	
7. Are you entitled to benefing or your employer including Details:	its under any accid	lent or sicknes rmanent healtl	s insurance	arranged by you	nce?			O Yes	O No
PETERSE	statemen	ts on this entire ap	pplication and	tand each of the quest	me from		(Dlage-	Intitial	

PILOT 08.12



MEDICAL INFORMATION

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If "Yes" is answered for any of the following, please provide full details in the space below or attach separately.

8. Have you had investigated, diagnosed, been treated for, any sympt	coms lasting longer than 1 month or recurring sy	mptoms of:				
a. any psychiatric or nervous disorder (including migraines), e	epilepsy or any other form of					
convulsions or any loss of consciousness?		O Yes O No				
b. any heart, blood pressure, circulatory or respiratory disorde	r?	O Yes O No				
c. any condition involving the eyes, nose and/or throat?		O Yes O No				
d. any condition involving the gastrointestinal tract or the gen	itourinary tract?	O Yes O No				
e. any disorder of the blood or lymphatic system?		O Yes O No				
f. any condition affecting the bones and/or joints (including sp	pine)?	O Yes O No				
g. any disorder of the skin?		O Yes O No				
h. diabetes?		O Yes O No				
i. any condition(s) not mentioned above?						
9. After or during a medical examination, have you ever:						
a. been required to take an additional test?						
b. been referred to a specialist for examination?		O Yes O No				
c. had the issue or renewal of your medical certificate deferred	<u> </u>	O Yes O No				
d. had to return for examination at less than the normal interv	ral time?	O Yes O No				
e. been ordered to take drugs or follow any specific diet?						
10. Has any insurance company or underwriter:						
a. declined or deferred an application you submitted?		O Yes O No				
b. charged or quoted more than standard rates?		O Yes O No				
c. cancelled or declined to renew your insurance?		O Yes O No				
11. Are you aware of any deterioration in your health, hearing, eyesig	ght or blood pressure?	O Yes O No				
12. Have you ever been grounded or had your license invalidated for medical reasons?						
13. Have you ever had any limitations or endorsements on your license?						
14. Are you currently taking any medications?						
Date of your last electrocardiograph examination approved by the lice	cense issuing authority:					
15. To the best of your knowledge and belief, are you in good health a described in this application? • Yes • No Question #: Details:	and free from any mental or physical impairmen	t, except as				
IT IS UNIDEDSTOOD	AAAM ACREEN					
1. that all answers on this application, to the best of my knowledge and belief, are complete and true; 2. that all answers on this application shall form the basis of the issuance of any coverage hereunder; 3. that in the event of any fraud, misstatement, concealment or failure to disclose information in any answers on this application, whether intentional or inadvertent, any coverage issued based upon this application may become void, and no benefit shall be payable; 4. the insurance applied for hereunder shall take effect on the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any answers on this application between the date of application and the effective date of the certificate; 5. no agent or broker or medical examiner has authority to waive or change any answer on this application; 6. that this application shall be attached to and form part of any coverage which may be subsequently issued; 7. I have read, or had read to me, and understand each of the questions and statements on this entire application; 8. no one has prevented me from spending as much time as I felt was necessary to understand this application.						
Date: Signature of Applicant	Signature of Policy Owner (if not Applicant) Date:					
Signature of Applicant	Signature of Folicy Owner (If flot Applicant)					

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