

# 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



**GIC Insurance Agency**

P.O. Box 291 Fair Grove, Missouri 65648

Phone:(417) 759-2009 • Fax: (417) 459-4870

[www.gicinsurance.com](http://www.gicinsurance.com) • [info@gicinsurance.com](mailto:info@gicinsurance.com)



# 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%		\$ _____
<b>TOTAL ANNUAL PREMIUM</b>		\$ _____

**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 policy does not cover any loss resulting from pregnancy, maternity, suicide or attempted suicide, intentionally self-inflicted injuries while sane or insane, alcoholism, drug addiction, mental or nervous disorders, subjective pain unless supported by objective medical findings as to the cause of the pain, the commission or attempted commission of a criminal or felonious act or serving in the military service of any country except for service in the military reserve of the United States.

War, declared or undeclared, riot or civil insurrection are not covered unless an additional premium has been paid to provide such coverage and the underwriters have accepted this extended risk.

*This is a brief description of the insurance provided by this plan.  
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](mailto: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.).

### **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](mailto:piu@piu.org)