RACERCOVER HIGH LIMIT INSURANCE

WORLD-WIDE COVERAGE

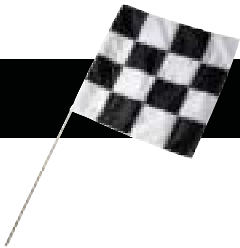
FOR

- *People in the Field of Professional Racing*
- *People Whose Avocation is Racing*

COVERING

- *Disability*
- *Accidental Death*
- *Major Medical*

GIC Insurance Agency
P.O. Box 291 Fair Grove, Missouri 65648
Phone:(417) 759-2009 • Fax: (417) 459-4870
www.gicinsurance.com • info@gicinsurance.com



RACERCOVER HIGH LIMIT INSURANCE

WORLD-WIDE COVERAGE

TOTAL DISABILITY BENEFITS

- **Weekly Benefits** are payable while totally disabled. Benefits begin the first day following the Deductible Elimination Period and pay for as long as the Benefit Period, for **each disability.**

  Benefits are payable for: 1) ❑ Accident Only or ❑ Accident and Sickness
  2) ❑ 24-Hour Coverage or ❑ While Practicing and Racing Only

PERIOD OF INSURANCE ____________	BENEFIT	ANNUAL PREMIUM
WEEKLY BENEFIT AMOUNT	$ ____________	$ ____________
ELIMINATION PERIOD	____________Days	
BENEFIT PERIOD, EACH DISABILITY	________ Weeks	
MAXIMUM BENEFIT, EACH CLAIM	$ ____________	

- **Per Race Missed Cash Indemnity** Amount is payable for each Scheduled Race missed because of being Totally Disabled during a benefit period.

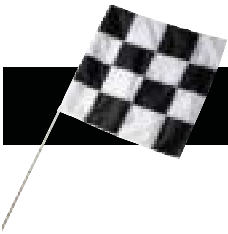
  Benefits are payable for 1) ❑ Accident Only or ❑ Accident and Sickness
  2) ❑ 24 Hour Coverage or ❑ While Practicing and Racing Only

PERIOD OF INSURANCE ____________	BENEFIT	ANNUAL PREMIUM
CASH INDEMNITY AMOUNT, EACH RACE	$ ____________	$ ____________
DEDUCTIBLE	# of ____Races	
BENEFIT PERIOD, UP TO	# of ____Races	
MAXIMUM BENEFIT, EACH CLAIM	$ ____________	

- **Total Disability** means that due to **sickness** or **injury** you cannot perform the material duties of your occupation.

  SICKNESS MEANS disease or illness which is first diagnosed while this Certificate is in force and results in a disability within 365 days of the date of diagnosis.
  INJURY MEANS accidental bodily injury sustained while the Certificate is in force and which results in disability within 365 days of the date of the accident.

This is not intended to be a complete outline of coverage.
Actual wording may change without notice. Proposal good for 30 days.



RACERCOVER HIGH LIMIT INSURANCE

WORLD-WIDE COVERAGE

PERMANENT TOTAL DISABILITY BENEFITS

- **Permanent Total Disability Benefit** is payable after the specified number of months of Total Disability has elapsed and it is determined by competent medical authority that you have suffered a Career Ending Disability.

Benefits are payable for 1) ❑ Accident Only or ❑ Accident and Sickness
2) ❑ 24 Hour Coverage or ❑ While Practicing and Racing Only

PERIOD OF INSURANCE ________	BENEFIT	ANNUAL PREMIUM
LUMP SUM BENEFIT	$ ________	$ ________
ELIMINATION PERIOD	________ Weeks	

THE PRINCIPAL SUM AMOUNT $ ________ **ANNUAL PREMIUM** $ ________

❑ Accident Death ❑ 24 Hour Coverage or ❑ While Practicing and Racing Only
❑ Accident Death & Disbursement ❑ 24 Hour Coverage or ❑ While Practicing and Racing Only

PERIOD OF INSURANCE ________	BENEFIT	ANNUAL PREMIUM
ACCIDENTAL	DEATH	PRINCIPAL SUM
ACCIDENTAL DISMEMBERMENT BENEFITS	TWO LIMBS	PRINCIPAL SUM
	BOTH EYES	PRINCIPAL SUM
	ONE LIMB	ONE HALF PRINCIPAL SUM
	HEARING, BOTH EARS	ONE HALF PRINCIPAL SUM
	LOSS OF SPEECH	ONE HALF PRINCIPAL SUM

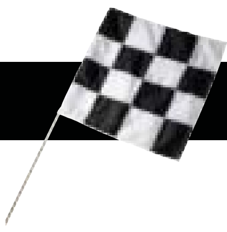
Optional Coverages: ❑ Acts of Terrorism or ❑ War, declared or undeclared

- Medical Expenses will be paid that exceed the Deductible Amount and the Co-Insurance Amount, up to the Maximum Benefit Amount for each injury or sickness.

Benefits are payable for 1) ❑ Accident Only or ❑ Accident and Sickness
2) ❑ 24 Hour Coverage or ❑ While Practicing and Racing Only

PERIOD OF INSURANCE ________	BENEFIT	ANNUAL PREMIUM
MAXIMUM BENEFIT AMOUNT	$ ________	$ ________
DEDUCTIBLE AMOUNT	$ ________	

This is not intended to be a complete outline of coverage.
Actual wording may change without notice. Proposal good for 30 days.



RACERCOVER HIGH LIMIT INSURANCE

WORLD-WIDE COVERAGE

SPECIFIED OCCUPATIONS

- These plans are Specific 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 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 for the balance of the plan term.

- **Total Disability and Missed Race Indemnity**

  You must be under the regular care of a legally qualified physician for benefits to be payable. If in the opinion of the physician, future or continued treatment would be of no benefit to you, regular care shall not be required.

- **Permanent Total Disability**
  - 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 have suffered a Career Ending Disability to be eligible for the Lump Sum Benefit.
  - 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 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.

- **Medical Expenses**
  - The Underwriters will pay necessary, usual and customary expenses for medical and surgical specialists' fees, hospital, nursing home and nursing attendance charges, cost of physiotherapy, massage and manipulative treatment, surgical and medical requisites, up to, but not exceeding the Maximum Benefit
  - Covered expenses must be necessarily incurred and arise from illness manifesting itself or accidental bodily injury occurring during the Period of Insurance

- This is a brief and general description of the insurance provided by the plan. The Certificate of Insurance is the complete description of coverage. Market conditions change as to special coverages. A general description is appropriate, but the finite description is to be found in the certificate.

- This endorsement does not cover death caused or contributed to by: war, declared or undeclared, or acts of terrorism (unless such coverage is applied for and the appropriate additional premium has been paid); intentional self-inflicted death caused by sickness or injury suicide, committing or attempting to commit a felonious act; taking of illegal or non-prescribed drugs, or addiction or misuse of prescription drugs.

This is not intended to be a complete outline of coverage.
Actual wording may change without notice. Proposal good for 30 days.

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.).

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