

# THE USAway INTERNATIONAL MAJOR MEDICAL PLAN

## *An International Major Medical Series Product*

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*FOR*

*People traveling  
or temporarily residing  
outside of the United States*

*USES*

*Business Assignments  
Pleasure  
Educational Pursuits  
Religious Activities*



## **PETERSEN INTERNATIONAL UNDERWRITERS**

*Lloyd's Correspondents*

23929 Valencia Boulevard Suite 215 Valencia California 91355-2186  
Telephone (800) 345-8816 (661) 254-0006 Facsimile (661) 254-0604  
E-Mail: [piu@piu.org](mailto:piu@piu.org) Website: [www.piu.org](http://www.piu.org)

**NOW**  
up to \$5 Million  
Maximum Benefit  
and all cause deductible  
**INCLUDES**  
Emergency Return Home  
Trip Cancellation  
Lost Luggage  
Accidental Death with  
Double Indemnity



# THE USAway INTERNATIONAL MAJOR MEDICAL PLAN

## PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Blvd., Suite 215 • Valencia, CA 91355-2186 • Tel (800) 345-8816

Underwritten by Certain Underwriters at Lloyd's

This is a temporary major medical insurance plan intended for indemnification of eligible expenses from injuries or illnesses which occur within a specified geographical area. Benefits may be assignable once validated. Until then, benefits are paid directly to you to reimburse you for necessary medical expenses which have been paid by you, subject to covered expenses as outlined in the certificate.

Proposed Insured: FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

Personal Statistics: DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX \_\_\_\_\_

Non-USA Address: NUMBER & STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

USA Address: NUMBER & STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

Telephone No.: \_\_\_\_\_ FAX \_\_\_\_\_ E-MAIL \_\_\_\_\_

Citizenship: \_\_\_\_\_ COUNTRIES IN WHICH COVERAGE WILL BE EFFECTIVE: \_\_\_\_\_

Business or Occupation: \_\_\_\_\_ PURPOSE OF TRAVEL \_\_\_\_\_

Last Medical Attendant : NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

Date & Reason Last Seen: \_\_\_\_\_

Usual Medical Attendant: NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

Date & Reason Last Seen: \_\_\_\_\_

Optional Coverages:  War Coverage  Cardiac/Cancer Limitation Removal  
(check all that apply)  Frequent Traveler  Hazardous Sports/Activities Coverage — Specify Sport/Activity \_\_\_\_\_

Period of Insurance: DAYS REQUIRED \_\_\_\_\_ BEGINNING\* \_\_\_\_\_ ENDING \_\_\_\_\_ DEDUCTIBLE \$ \_\_\_\_\_

\*Earliest Effective Date is 24 hours AFTER underwriting approval.

### PLEASE ANSWER ALL THE QUESTIONS

- |  |  |   |  |
|--|--|---|--|
| 1) Do you have any physical defect of infirmity?   | <input type="checkbox"/> YES <input type="checkbox"/> NO | 6) a) Have you ever undergone a surgical operation?   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2) Is your sight or hearing defective?   | <input type="checkbox"/> YES <input type="checkbox"/> NO | b) Have you any reason to believe that a surgical operation may be necessary in the future?                       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3) Have you ever suffered from any nervous or mental condition, fainting episode, blackout, headaches or migraines, seizures or paralysis of any kind? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 7) Have you ever been declined or accepted on special terms for life, accident or illness insurance?              | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4) Have you ever suffered from:  |  | 8) Do you intend to engage in winter sports or any other pastimes that expose you to extra personal injury?       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| a) high blood pressure, a heart condition, rheumatic fever or diabetes?  | <input type="checkbox"/> YES <input type="checkbox"/> NO | 9) Are there any additional facts affecting the proposed insurance which should be disclosed to the underwriters? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b) a "slipped disc" or other spinal disorder, a hernia or any rheumatic or arthritic condition?  | <input type="checkbox"/> YES <input type="checkbox"/> NO | 10) Are you currently taking any medication?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| c) any respiratory, urinary or allergic condition, or any disorder of the stomach or bowels?   | <input type="checkbox"/> YES <input type="checkbox"/> NO | 11) Do you have any other medical insurance at this time?   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| d) any other condition requiring medical investigation or hospital treatment?  | <input type="checkbox"/> YES <input type="checkbox"/> NO | 12) Have you ever been insured by this plan or any other medical plan through Lloyd's of London?                  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5) Have you ever suffered from any other conditions or injuries for which medical advice was sought?   | <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |

DATES AND DETAILS \_\_\_\_\_

### AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health, to Petersen International Underwriters.

### DECLARATION

I declare that the above statements are true and complete, and that, apart from the matters declared above, I am in good health and ordinarily enjoy good health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctor to give this information. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that pre-existing conditions are not covered until a period of insurance of 12 months, treatment free, has elapsed.

Proposed Insured \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# THE USAWAY INTERNATIONAL MAJOR MEDICAL PLAN

## DESCRIPTION OF AVAILABLE BENEFITS

### DEDUCTIBLE

Choice of a  
\$250, \$500, \$1,000 or \$2,500  
deductible per person

### COINSURANCE

After the Deductible is paid, **80%**  
of the next \$5,000 of the eligible  
expenses are paid by Underwriters  
and then 100% of eligible expense  
to the maximum benefit

### MAXIMUM BENEFIT

up to  
**\$5,000,000**  
for all eligible expenses  
(see limitations)

## SUMMARY OF BENEFITS

*The insurance being described is a temporary major medical plan to be used by United States residents while traveling internationally. Eligible expenses caused by an illness or injury and are incurred from any doctor or any hospital outside the USA, and for which are not excluded will be reimbursed to you based upon usual, customary and reasonable charges. Benefits may be assignable directly to the providers once a Claim Review has been completed.*

## ELIGIBLE EXPENSES

**Hospital Expenses:** All medically necessary expenses while hospitalized.

**Physician Services:** All medically necessary expenses for treatment.

**Skilled Nursing Facilities:** All medically necessary expenses if confinement begins following a medically necessary hospital confinement of 3 days or longer.

**Home Health Care:** All medically necessary expenses if hospitalization would have been required if Home Health Care was not provided and the care is provided in accordance with a written plan established, approved and followed by a physician.

**Ambulance Services Expenses:** To and from a hospital within 100 miles in the same geographic area.

**Prescription Drugs:** Covered during and following a period of hospitalization.

**Repatriation of Remains:** In the event of death, Underwriters will reimburse the cost of delivery of your remains to a mortuary nearest your home.

**Common Accident Provision:** In the event that you and any additional insured family members suffer injuries from the same accident, only one deductible and coinsurance shall be applied.

**Global Medical Transportation:** All medically necessary expenses for stabilization and transportation to the facility nearest your home, which can provide the appropriate care.

**Lost Luggage:** In the event that your checked on luggage is completely and totally lost, Underwriters shall reimburse you to a maximum of \$500, excess of any and all other valid and collectible coverages.

**Trip Cancellation Benefit:** If within two weeks prior to Your pre-paid ticketed or vouchered trip departure Your trip must be cancelled due to 1) Your death, illness or injury causing hospitalization or outpatient surgery, or 2) the death of an Immediate Family member, or 3) the substantial destruction of Your home due to fire, wind flood, or earthquake, any unused and non-refundable portion of expenses, shall be reimbursed up to a maximum of \$1,000, excess of \$100 each and every loss and excess of all other valid Insurances.

**Emergency Return Home:** If, after You have departed, You learn of the death of an Immediate Family Member, or You learn of the substantial destruction of Your home by fire, wind, flood, or earthquake, Underwriters shall reimburse You the cost of an economy one way air or ground transportation ticket for You to Your home, up to a maximum of \$5,000.

**\$25,000 Accidental Death:** Double indemnity (\$50,000 total) if accidental death occurs while riding as a passenger of a common carrier.

**Follow Me Home:** Provides benefits for any injury or illness which occurs while in the USA. Benefits are limited to 2 weeks for every 3 months of time outside the USA.

*This is not intended to be a complete outline of coverage. Actual wording may change without notice.*

*Underwriters reserve the right to modify terms and benefits at time of underwriting.*



## OPTIONAL COVERAGES

### Hazardous Sports or Activity Coverage

If you elect this option, underwriters will reimburse you for eligible expenses which are incurred due to an injury resulting from the participation in a Hazardous Sport or Activity that is specifically named on the Schedule of Coverage.

*(See exclusions for list of commonly excluded sports and activities.)*

### War or Act of War Coverage

If you elect this option, underwriters will reimburse you for eligible expenses which are incurred as a result of injuries sustained due to war or act of war.

Please Note: War and acts of war does not include acts of terrorism. Acts of terrorism is included in the base plan at no extra charge.

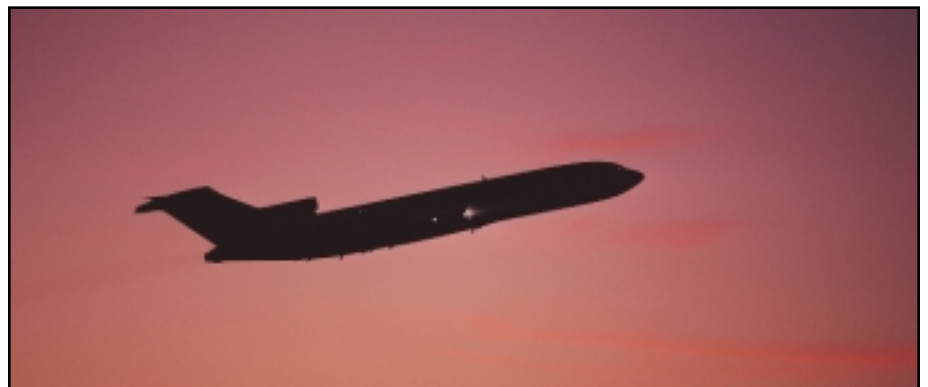


### Frequent Travelers Option

This option allows you to purchase a specified number of days of coverage, within the next 12 months, to allow you to leave the U.S.A. as frequently as you desire without applying for coverage each time.

### Cardiac and Cancer Limitations Removal

This option makes cardiac and cancer related conditions the same as any other expense. This option is available only to U.S. residents under the age of 60.



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# THE USAway INTERNATIONAL MAJOR MEDICAL PLAN

## PREMIUM CALCULATIONS

1 MONTH (For periods other than 1 month, see "To Calculate")				
AGE	\$250 Deductible	\$500 Deductible	\$1000 Deductible	\$2500 Deductible
0-17*	31	31	31	31
18-29*	48	46	42	37
30-39	62	59	53	47
40-49	92	87	78	69
50-59	113	107	95	84
60-64	171	162	145	127
65-69	243	195	173	154
70-74	N/A	N/A	173	154
75-79	N/A	N/A	205	195
80-84	N/A	N/A	N/A	284

\* If applying with an adult, otherwise use 18-29 rates

### TO CALCULATE

- 1) Determine the deductible you want.
- 2) Using actual age, add up the total 1 month premium for each person to be insured.
- 3) For 2 weeks or less of coverage, multiply the 1 month premium total by 0.70. For all other calculations, multiply the 1 month premium by the total months of coverage needed (to 12 months maximum).
- 4) Sub-total
- 5) Add any optional coverages to this sub-total
- 6) Add a \$100 processing fee
- 7) Do not send money until AFTER approval by Underwriters

### OPTIONAL COVERAGES

Cardiac/Cancer Limitation Removal	=	add 10%
Frequent Traveler	=	Determine the number of months you will be traveling within the next 12 months. Add one (1) extra month to this time. Calculate premiums based upon the adjusted time. Example: 3 months of coverage over the next 12 months, would be calculated as a 4 month premium.
Recreational Snow Skiing	=	add 10% or \$80 whichever is greater
Recreational Scuba Diving	=	add 10% or \$80 whichever is greater
All other Hazardous Sports/Activities	=	call
War Coverage	=	Call

*Actual premium and wordings may change without notice*

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# THE USAway INTERNATIONAL MAJOR MEDICAL PLAN

## LIMITATIONS

*Expenses which have limitations are as follows:*

- 1) Services and supplies for Cardiac Related Conditions and Cancer Related Conditions are limited to either (i) the medical costs of stabilizing your condition and the transportation costs of returning you to your Home Country or (ii) a maximum reimbursement for Eligible Expenses of \$25,000, at the option of Underwriters.
- 2) The maximum Eligible Expense for Global Medical Transportation is \$100,000.
- 3) The maximum Eligible Expense for room and board charges is \$450 per day.
- 4) The maximum Eligible Expense room and board charge for an intensive care unit is the lesser of three times the Provider's semi-private room and board charge or \$1350 per day.
- 5) Insured ages 70-74 are limited to \$250,000 maximum benefit, all other terms and conditions apply.
- 6) Insured ages 75-79 are limited to \$100,000 maximum benefit, all other terms and conditions apply.
- 7) Insureds ages 80-84 are limited to \$50,000 maximum benefit, all other terms and conditions apply.

## PREEXISTING CONDITIONS LIMITATIONS

A Preexisting Condition will not be covered until the insurance described in this certificate has been in effect for a period of 12 months. A preexisting condition is one in which an insured sought medical attention or was advised to seek medical attention during the 12 month period preceding the effective date of the coverage.

## EXCLUSIONS

*Expenses which are not eligible for reimbursement are as follows:*

- 1) Any expense which you are not legally obligated to pay.
- 2) Services which are not Medically Necessary or are not furnished by and under supervision of a Physician.
- 3) Expenses for services and supplies for which you are entitled to benefits, services or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan or from any other source except Medicaid.
- 4) Expenses in excess of Usual, Customary and Reasonable (UCR).
- 5) Outpatient drugs, except following a hospitalization if prescribed for the same illness or injury.
- 6) Self-inflicted injuries while sane or insane.
- 7) Treatment for alcoholism, drug addiction, allergies, and/or Mental or Nervous Disorders.
- 8) Rest cures, quarantine or isolation.
- 9) Cosmetic surgery unless necessitated by an accidental injury.
- 10) Dental exams, dental x-rays and general dental care except as a result of an accidental injury.
- 11) Eye glasses or eye examinations.
- 12) Hearing aids or hearing examinations.
- 13) General or routine examinations.
- 14) Injuries sustained from participation in Hazardous Sports or Activities which in part include mountaineering, snow skiing, scuba diving, hang gliding, sky diving, racing of any kind, and all professional or semi-professional sports.
- 15) Pregnancy and pregnancy-related conditions including but not limited to fertility, pre-natal care, childbirth, miscarriage, pre-mature births, or abortion or complications from pregnancy to either mother or baby.
- 16) Injuries or illnesses due to war or any act of war whether declared or undeclared. (Note: Terrorism however is included in the base policy of benefits.)
- 17) Injuries or illnesses sustained while committing a criminal or felonious act.
- 18) Expenses incurred for or resulting from pain which is not supported by medical diagnosis.
- 19) Cataract surgery or any elective surgery.
- 20) Custodial Care.
- 21) Expenses for supplies and services that were not incurred within the specified Geographic Area.
- 22) Pre-existing Conditions.

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# **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.).

### **Right to access or correct your personal information**

You have a right to request access to or correction of your personal information in our possession.

### **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)

# 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 PERSONAL INFORMATION HIPAA Compliant

**I AUTHORIZE** any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, 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 provide to Petersen International Underwriters, Inc., or to any agency authorized by Petersen International Underwriters, Inc to collect any and all such information by means of U.S. Post , fax or e-mail.

**I AUTHORIZE** Petersen International Underwriters to communicate with me/us or our representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, or additional coverages from Petersen International Underwriters.

**I UNDERSTAND** the purpose of this Authorization is to allow Petersen International Underwriters, Inc., to determine eligibility for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by Petersen International Underwriters, Inc., to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with my application, 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 UNDERSTAND** that I may revoke this Authorization, except to the extent that Petersen International Underwriters, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to Petersen International Underwriters Inc.. Any such revocation may also have an impact upon my Underwriting or claims processing.

**I UNDERSTAND** that I can obtain a complete copy of Petersen International Underwriters Inc. Privacy Policy either on Petersen International Underwriters, Inc. website or by contacting them directly and asking for a copy.

**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 years from the date shown below.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
*Signature of Proposed Insured*