

# GROUP INTERNATIONAL MAJOR MEDICAL PLANS

*An International Major  
Medical Series Plan*



## **FOR**

*Foreign Nationals while  
Visiting the U.S.A.*

*U.S.A. Citizens Residing or Traveling  
outside the U.S.A.*

*Foreign Nationals who reside  
outside the U.S.A. and who  
work for a U.S.A. Firm*

## **USES**

*Business Assignments*

*Pleasure*

*Educational Pursuits*

*Religious Activities*

## **PLANS AVAILABLE FOR**

*Short Term*

*Multiple Trips*

*Long Term*



## **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)



# PROPOSAL REQUEST/APPLICATION

Please Return To:

**PETERSEN INTERNATIONAL UNDERWRITERS**  
23929 Valencia Blvd., Suite 215 • Valencia, CA 91355 • Tel (800) 345-8816  
*Underwritten by Certain Underwriters at Lloyd's*

## PART I. General

Full Name of Company or Group: \_\_\_\_\_

Type of Company: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Target Effective Date: \_\_\_\_\_ Is coverage to be: On-going?  or Fixed time period?

If fixed, length of cover needed: \_\_\_\_\_

## PART II. Prior Coverage

Does this group have current coverage or had prior coverage? YES  NO

If Yes please indicate for at least past three years: Name of Carrier: \_\_\_\_\_

Reason for changing: \_\_\_\_\_ Please attach Loss data as detailed as possible

## PART III. About the Employees or Group Participants

Full-Time People: Total in Group: \_\_\_\_\_ Total to be covered under this plan: \_\_\_\_\_

Part-time People: Total in Group: \_\_\_\_\_ Total to be covered under this plan: \_\_\_\_\_

Number of people to be covered by age band: Under 30 \_\_\_\_ 30-39 \_\_\_\_ 40-49 \_\_\_\_ 50-59 \_\_\_\_ 60-64 \_\_\_\_ 65+ \_\_\_\_

Should this proposal include an option for dependents? YES  NO

Should this proposal include cover in the USA? YES  NO

**A census of the group to be covered, including names, addresses, and dates of birth will be needed during final underwriting.**

Will this be:  Voluntary or  Non-voluntary

If you could design your own plan, what benefits would you include?:

Deductible: \$ \_\_\_\_\_ Co-insurance: \_\_\_\_\_ Maximum benefit: \$ \_\_\_\_\_ Target Monthly Premium: \$ \_\_\_\_\_

Other Requests?: \_\_\_\_\_

Other Thoughts or Comments?: \_\_\_\_\_

Rate and plan design guarantees, premium billings, and addition of new employees are subject to change from group to group. These items will be provided with a proposal. Contract disputes are required to go before binding arbitration. If you already have a proposal, please attach a copy of the plan desired for final underwriting approval. Once received, this application and information shall be reviewed and full market support will be sought. Coverage cannot be bound until there is 100% market support. Completion of this Proposal/Application does not constitute an offer or acceptance.

**Signature of Company/Group Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name and Title:** \_\_\_\_\_



# GROUP INTERNATIONAL MAJOR MEDICAL PLANS

The following is a description of a standard basic plan design. Alternative designs are available on a case by case basis. Each plan is designed to best fit the size and needs of the group. In some cases, provisions of the following description may be enhanced or deleted.

## DESCRIPTION OF TYPICAL BENEFITS

DEDUCTIBLE	COINSURANCE	MAXIMUM BENEFIT
Choice of \$100, \$250, \$500, \$1,000, \$2,500 or Higher per illness or injury	After the deductible Underwriters will reimburse 80% of next \$5,000 in eligible expenses and then 100% up to the Maximum Benefit	\$25,000 - \$5,000,000

## SUMMARY OF BENEFITS

Eligible expenses caused by an illness or injury and incurred from any doctor or any hospital within a specified geographical area will be reimbursed to you. Benefits may be assignable directly to the providers once a Claim Review has been completed.

### ELIGIBLE EXPENSES

#### Hospital Expenses including:

Semi-private room and board, intensive care, other medically necessary hospital services and supplies, such as emergency room care, outpatient surgery, diagnostic services, supplies and therapy.

#### Physician Services Consisting of:

Home, office, and hospital visits, diagnostic services, supplies and therapy.

#### Skilled Nursing Facility including:

Room and board, provided confinement begins within 30 days following a medically necessary hospital confinement of three days or longer.

#### Home Health Care:

If hospitalization would have been required if Home Health Care were not provided, and the Home health Care is provided in accordance with a written plan established and approved by a physician.

#### Ambulance Services:

To and from a hospital in the geographic area.

#### Prescription Drugs:

Covered during and following a period of hospitalization.

#### Repatriation of Remains:

In the case of death, underwriters will reimburse the costs of delivery of your remains to a mortuary near 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 Coverage:

Underwriters will reimburse you for the costs of medically necessary transportation to return you to the facility nearest your home which can provide appropriate care, up to \$100,000.



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



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Alternative designs are available on a case by case basis.*

## LIMITATIONS

*Expenses which have limitations are as follows:*

- 1) The maximum Eligible Expense for room and board charges is \$450 per day.
- 2) The maximum Eligible Expense room and board charge for an intensive care unit is three times the Provider's semi-private room and board charge or \$1350 per day whichever is the least.
- 3) Insured age 70-74 are limited to \$250,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.
- 4) Insured age 75-79 are limited to \$100,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.
- 5) Insured age 80-84 are limited to \$50,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.

## 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 policy.

## 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 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
- 8) Mental or nervous disorders.
- 9) Rest cures, quarantine or isolation.
- 10) Cosmetic surgery unless necessitated by an injury.
- 11) Dental exams, dental x-rays and general dental care except as a result of an injury.
- 12) Eye glasses or eye examinations.
- 13) Hearing aids or hearing examinations.
- 14) General or routine examinations.
- 15) Injuries sustained from participation in Hazardous Sports or Activities
- 16) Pregnancy and pregnancy-related conditions including but not limited to fertility, pre-natal care, childbirth, miscarriage, abortion or postpartum conditions.
- 17) Injuries or illnesses due to war or any act of war whether declared or undeclared.
- 18) Injuries or illnesses sustained while committing a criminal or felonious act.
- 19) Expenses incurred for or resulting from pain which is not supported by medical diagnosis.
- 20) Cataract surgery
- 21) Any elective surgery.
- 22) Custodial Care.
- 23) Expenses for supplies and services that were not incurred within the specified Geographic Area.
- 24) Pre-existing conditions.

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

# **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)

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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*