The Bridge Plan Application Form

Producer Number: 51752

To be eligible for the Bridge Plan coverage, you must not be eligible for Medicare. **If you have been a legal resident of the USA for five years, you are eligible to purchase Medicare and you should not complete this application.** Benefits are subject to all terms, limitations and conditions outlined in your certificate. Please read your certificate carefully once you receive it.

Applicant's Name: First _____ Middle _____ Last _____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ❑Male ❑Female

Residence Address: _____

City _____ State _____ Zip Code _____

E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____

Requested Start Date: _____ Date you expect to be eligible for Medicare: _____

Plan Type: ❑ **Platinum** *($1,000,000 Max. & $1,000 Deductible)* ❑ **Gold** *($500,000 Max. & $2,500 Deductible)*
❑ **Silver** *($250,000 Max. & $5,000 Deductible)* ❑ **Bronze** *($100,000 Max. & $10,000 Deductible)*

Coverage Type: ❑ Bridge Part A & B ❑ Bridge Part A Only ❑ Bridge Part B Only

Last healthcare provider seen: a. Date and reason last seen: _____
b. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided below or attach a separate page if needed

1. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ❑ Yes ❑ No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
3. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ❑ Yes ❑ No
4. Have you ever been evaluated or treated for any injury, condition or disorder involving the following? ❑ Yes ❑ No

a.	Eyes/Ears	❑ Yes ❑ No	o.	Back/spine/neck	❑ Yes ❑ No
b.	Gout	❑ Yes ❑ No	p.	Throat/Thyroid/Glands	❑ Yes ❑ No
c.	Skin	❑ Yes ❑ No	q.	Bones/Bone Density	❑ Yes ❑ No
d.	Hernia	❑ Yes ❑ No	r.	Arthritis/Joints (Hips Knees, Shoulders)	❑ Yes ❑ No
e.	Diabetes	❑ Yes ❑ No	s.	Fainting/Dizziness/Unconsciousness	❑ Yes ❑ No
f.	HIV/AIDS	❑ Yes ❑ No	t.	Fatigue/Tiredness/Paralysis/Weakness	❑ Yes ❑ No
g.	Sleep apnea	❑ Yes ❑ No	u.	Nervous System/Alzheimer's/Dementia	❑ Yes ❑ No
h.	Gallbladder	❑ Yes ❑ No	v.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
i.	Concussions	❑ Yes ❑ No	w.	Respiratory System/Asthma	❑ Yes ❑ No
j.	Chronic Pain	❑ Yes ❑ No	x.	Circulatory system	❑ Yes ❑ No
k.	Lymph nodes	❑ Yes ❑ No	y.	Reproductive system	❑ Yes ❑ No
l.	Cancer/Growth	❑ Yes ❑ No	z.	Gastrointestinal System	❑ Yes ❑ No
m.	High blood pressure	❑ Yes ❑ No	aa.	Urinary system/Prostate	❑ Yes ❑ No
n.	Heart/Chest Pain/Stroke	❑ Yes ❑ No	ab.	Any other condition not listed above	❑ Yes ❑ No

5. Has your weight changed in the past year? ❑ Yes ❑ No
6. Have you ever undergone a surgical operation? ❑ Yes ❑ No
7. Have you taken any medicines in the past 12 months? ❑ Yes ❑ No
8. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed? ❑ Yes ❑ No
9. Other than the medical conditions noted on this application, I am in good health. ❑ Yes ❑ No
10. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

DECLARATION

I declare that the above statements are true and complete. I am in good health and ordinarily enjoy good health. 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 this is a temporary insurance policy designed to cover the insured person for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product. I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured _____ Signature _____ Date _____
Please Print

Payment Authorization Form

Petersen International Underwriters
23929 Valencia Boulevard, Second Floor, Valencia, CA 91355
Phone (800) 345-8816 • Fax (661) 254-0604 • payment@piu.org

❍ Pre-Authorized Monthly $_____

Insured's Name		
Account Billing Address		
City	State	Zip
Email		Phone

Option 1) Credit Card -

Card #

Expiration Date: /

Security Code:

Name on Card:

Option 2) Electronic Check - **(Must be a U.S. Bank Account)**

Select Account Type:

☐ **Checking**

☐ **Saving**

Routing # *(9-digits)*

Account #

Name on Account

Please Include a Copy of a Voided Check

I understand that this authorization will remain in effect until Petersen International Underwriters receives a written request from me to cancel my automatic withdrawal at least 3 days prior to the next scheduled withdrawal or until Petersen International Underwriters elects to cancel this agreement. I understand that if two or more deductions are not honored, Petersen International Underwriters has the right to discontinue my enrollment in the Electronic Funds Transfer Payment Plan. I hereby authorize Petersen International Underwriters to debit my account for the correct installment premium on the due dates of the installments. I understand that my coverage is not in effect until all requirements have been submitted and approved by Petersen International Underwriters. I acknowledge that the origination of EFT transactions to my account must comply with the provision of U.S. law.

Signature: _____ **Date**: _____