Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093 | Phone: (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

INSUBUY®
Same Price. Better Service.®

+1 (866) INSUBUY
467-8289

Disclaimer

Insurance can be effective only after the underwriting department receives and reviews your application. The earliest effective date will be the next day after the review.

Underwriting department is open from Monday through Friday, 7 AM to 4 PM, Pacific Time, excluding holidays.

By submitting this paper application, you acknowledge and agree that:

- Back dated applications are not possible.
- Requested effective date is not always guaranteed.
- It does not matter when you send the application by postal mail, fax or scanned copy in email.
- It does not matter when the postal mail, fax or email was received by us, as the underwriting department can consider the effective date only according to when they review the application.
- If there is any dispute between you and the underwriting department about when the effective date should be, the decision of the underwriting department will be final.
- You hold Insubuy and the writing agent (if any) harmless and relieve us from any liability because of this.

If the above terms are not acceptable to you, please do not submit the application.

If you need to purchase the insurance urgently with a specific effective date, please call our office at +1 (866) INSUBUY or the writing agent to confirm, before sending the application.

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The Bridge Plan Application Form

Producer Number:_______________

To be eligible for the Bridge Plan coverage, you must attest to the following statements:

❑ I attest that I am not eligible for Medicare or Affordable Care Act (ACA) compliant insurance.

❑ I attest that I have tried, but was unable to obtain short-term medical insurance.

Reason why: ____

Applicant's Name: First ____________________ M.I. ________ Last ____________________

Date of Birth: ______ / ______ / ________ Height: ______ Weight: __________ Sex: ❑Male ❑Female

Residence Address: ____

City ____________________ State ______________ Zip Code ______________

Email Address: ____________________ Telephone (_____) _______ - _________

Requested Start Date: ______________ Date eligible for Medicare or ACA Coverage: ______________

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

Primary Care Physician:

a. Name: ____

b. Address: ____

c. Date and reason last seen: ____

d. Results of last visit: ____

If "Yes" is answered, please provide full details in the area provided 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. Has your weight changed in the past year? ❑ Yes ❑ No
5. Have you ever undergone a surgical operation? ❑ Yes ❑ No
6. Have you taken any medicines in the past 12 months? ❑ Yes ❑ No
7. 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
8. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No
9. Date and results of last colonoscopy: ______________________________
10. Date and results of last pap (female): ______________________________
11. Date and results of last mammogram (female): ______________________________
12. Date and results of last PSA (male): ______________________________

Question # ________ Dates & Details: ____

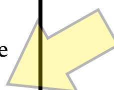
Question # ________ ____

Question # ________ ____

Question # ________ ____

PLEASE INITIAL THE FOLLOWING

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application. ______________



Last Healthcare Provider Seen:
a. Name: ______
b. Address: ______
c. Date and reason last seen: ______
d. Results of last visit: ______

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

13. Have you ever been evaluated or treated for any injury, condition or disorder involving the following:

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

Question#	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery

14. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application? ❑ Yes ❑ No - If No, please provide details: ______

______

______

IT IS UNDERSTOOD AND AGREED: 1) That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true, 2) That all answers on this application shall form the basis of the issuance of any coverage hereunder, 3) That in the event that You, the Loss Payee, the Owner or any person on Your behalf commits fraud, a misstatement or concealment either in the application or by any other statement, this Certificate may become void and no benefits will be payable, 4) That except as amended by the answers to the above questions, any answer shown on any prior application for this coverage signed and dated by me are expressly reaffirmed, 5) I have read or had read to me and understand each of the questions and statements on this entire application, 6) No one has prevented me from spending as much time as I felt was necessary to understand this application, 7) I understand the terms and conditions of this product, and 8) 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

Authorization to Release Personal Information

In Compliance with HIPAA & Financial Privacy Regulation

I, the proposed insured, authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/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 all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, HIV Tests/Test Results, and any other pertinent medical information.

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. Additionally, it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. 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.

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 that I have signed this Authorization.

Proposed Insured Name	Date of Birth
Legal Representative*	Relationship
Email	

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

Signature of Proposed Insured ____________________ Date ____________

Signature of Legal Representative (if other than Proposed Insured) ____________________ Date ____________

PETERSEN®
INTERNATIONAL UNDERWRITERS

Payment Authorization Form

Insubuy, Inc,
4200 Mapleshade Ln, Suite 200, Plano, TX 75093
Phone (866) INSUBUY • Fax (972) 767-4470 • info[at]insubuy.com

Insured's Name: First ______________ M.I. ______ Last ______________

Account Billing Address: ______________________________

City ______________ State ______________ Zip Code ______________

E-mail: ______________________________ Telephone (_______) ________ - ________

Option 1) ACH Payment - Please include a Voided Check (Must be a U.S. Bank Account)

Name on Bank Account: ______________________________ Account Type: ❑ Checking ❑ Saving

Routing # (9-digits): ______________________ Account #: ______________________

Payment Mode/Amount:

❑ Multi-Year Single Payment: $________________
❑ One Payment Only: $________________
❑ Pre-Authorized Annual: $________________
❑ Pre-Authorized Semi-Annual (Annual x .55): $________________
❑ Pre-Authorized Quarterly (Annual x .285): $________________
❑ Pre-Authorized Monthly* (Annual x .088): $________________

Option 2) Credit Card - $50,000 Annual Premium Maximum

Name on Card: ______________________ Card #: ______________________

Expiration Date: __________ / __________ Security Code: ______________

Payment Mode/Amount:

❑ Multi-Year Single Payment: $________________ **\$50,000 maximum*
❑ One Payment Only: $________________ **\$50,000 maximum*
❑ Pre-Authorized Annual: $________________ **\$50,000 maximum*
❑ Pre-Authorized Semi-Annual (Annual x .55): $________________ **\$27,500 maximum*
❑ Pre-Authorized Quarterly (Annual x .285): $________________ **\$14,250 maximum*
❑ Pre-Authorized Monthly* (Annual x .088): $________________ **\$4,400 maximum*

**Monthly payments must be pre-authorized*

I UNDERSTAND THAT PREMIUM IS NOT REFUNDABLE. PREMIUM PAID IS FULLY EARNED ONCE PAID.

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 three 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 ACH/Credit Card 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.

______ (initial) I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form. I further agree to authorize Petersen International Underwriters to charge my credit card for the services provided, and in the event my credit card becomes invalid, I will provide a new credit card upon request to be charged for the payment of any past due balances owed. I confirm that, unless I timely cancel this agreement, as set forth in the foregoing section, I am acknowledging receipt of the services and goods set forth in such invoice.

______ (initial) Charges made for actual services performed by Petersen International Underwriters are non-refundable and cannot be reversed by the credit card issuer. I hereby waive my right of refund and will not dispute with my credit card issuer any charges to my credit card in accordance with this Agreement with Petersen International Underwriters.

Account Holder Signature: ______________________________ **Date:** ______________

Monthly Premium Rates

Age	Platinum $1,000,000 Maximum Benefit $1,000 Deductible	Gold $500,000 Maximum Benefit $2,500 Deductible	Silver $250,000 Maximum Benefit $5,000 Deductible	Bronze $100,000 Maximum Benefit $10,000 Deductible
60	$844	$568	$376	$284
61	$848	$586	$397	$302
62	$854	$604	$419	$320
63	$858	$621	$443	$340
64	$862	$639	$465	$358
65	$867	$657	$488	$376
66	$871	$675	$510	$394
67	$875	$692	$532	$414
68	$879	$710	$555	$433
69	$885	$728	$577	$451
70	-	$746	$599	$471
71	-	$764	$623	$491
72	-	$782	$644	$509
73	-	$800	$666	$527
74	-	$817	$690	$545
75	-	$835	$711	$565
76	-	$853	$735	$583
77	-	$871	$757	$601
78	-	$888	$779	$620
79	-	$906	$802	$639
80	-	-	-	$782
81	-	-	-	$807
82	-	-	-	$830
83	-	-	-	$853
84	-	-	-	$876
85	-	-	-	$901
86	-	-	-	$924
87	-	-	-	$947
88	-	-	-	$972
89	-	-	-	$995
90+	Contact Our Office For Options.			

Additional Calculations:

- For Part A coverage only = above rates x .60
- For Part B coverage only = above rates x .60

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