

# MONTHLY PREMIUM RATES

Age	\$1,000 Deductible	\$1,500 Deductible	\$2,500 Deductible	\$5,000 Deductible	\$10,000 Deductible
60	\$366	\$316	\$258	\$212	\$204
61	\$372	\$322	\$265	\$217	\$207
62	\$378	\$328	\$272	\$222	\$210
63	\$384	\$334	\$279	\$227	\$213
64	\$390	\$340	\$286	\$232	\$216
65	\$395	\$344	\$293	\$238	\$221
66	\$413	\$359	\$301	\$246	\$227
67	\$431	\$374	\$309	\$254	\$233
68	\$449	\$389	\$317	\$262	\$239
69	\$467	\$404	\$325	\$270	\$245
70	\$484	\$419	\$335	\$279	\$252
71	\$502	\$433	\$349	\$290	\$260
72	\$520	\$447	\$363	\$301	\$268
73	\$538	\$461	\$377	\$312	\$276
74	\$556	\$475	\$391	\$323	\$284
75	-	\$490	\$408	\$336	\$296
76	-	\$504	\$421	\$345	\$304
77	-	\$518	\$434	\$354	\$312
78	-	\$532	\$447	\$363	\$320
79	-	\$546	\$460	\$372	\$328
80	-	-	\$476	\$381	\$336
81	-	-	\$489	\$424	\$368
82	-	-	\$502	\$467	\$400
83	-	-	\$515	\$510	\$432
84	-	-	\$528	\$553	\$464
85	-	-	-	\$598	\$500
86	-	-	-	\$641	\$534
87	-	-	-	\$684	\$568
88	-	-	-	\$727	\$602
89	-	-	-	\$770	\$636
90	-	-	-	-	\$673
91	-	-	-	-	\$707
92	-	-	-	-	\$741
93	-	-	-	-	\$775
94	-	-	-	-	\$809
95	-	-	-	-	\$843

**Additional Calculations:**

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



## THE BRIDGE PLAN APPLICATION FORM PAGE 2 OF 2

For any questions that you answer “YES,” please provide details of the medical condition including treatment, dates, diagnosis, prognosis, and present course of treatment in the area provided below or if additional space is needed please use a separate sheet and submit the it along with the application. Please attach these responses to this application. Underwriters may request additional medical information.

9. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?
- |   |  |
|---|--|
| a. Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b. Ears <input type="checkbox"/> Yes <input type="checkbox"/> No<br>c. Nose <input type="checkbox"/> Yes <input type="checkbox"/> No<br>d. Cyst <input type="checkbox"/> Yes <input type="checkbox"/> No<br>e. Gout <input type="checkbox"/> Yes <input type="checkbox"/> No<br>f. Knees <input type="checkbox"/> Yes <input type="checkbox"/> No<br>g. Back/spine/neck <input type="checkbox"/> Yes <input type="checkbox"/> No<br>h. Skin <input type="checkbox"/> Yes <input type="checkbox"/> No<br>i. Liver <input type="checkbox"/> Yes <input type="checkbox"/> No<br>j. Heart <input type="checkbox"/> Yes <input type="checkbox"/> No<br>k. Blood <input type="checkbox"/> Yes <input type="checkbox"/> No<br>l. Bones <input type="checkbox"/> Yes <input type="checkbox"/> No<br>m. Throat <input type="checkbox"/> Yes <input type="checkbox"/> No<br>n. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No<br>o. Fatigue/Tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No<br>p. Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>q. Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No<br>r. Kidneys <input type="checkbox"/> Yes <input type="checkbox"/> No<br>s. Glands <input type="checkbox"/> Yes <input type="checkbox"/> No<br>t. Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No<br>u. Pancreas <input type="checkbox"/> Yes <input type="checkbox"/> No<br>v. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No<br>w. Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No<br>x. Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No<br>y. HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No<br>z. Sleep apnea <input type="checkbox"/> Yes <input type="checkbox"/> No | aa. Gall bladder <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ab. Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ac. Concussions <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ad. Blood vessels <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ae. Lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No<br>af. Intestinal tract <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ag. Urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ah. Arthritis/joints/rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ai. Nervous system <input type="checkbox"/> Yes <input type="checkbox"/> No<br>aj. Growth/tumor/cancer <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ak. Unconsciousness <input type="checkbox"/> Yes <input type="checkbox"/> No<br>al. Circulatory system <input type="checkbox"/> Yes <input type="checkbox"/> No<br>am. Fainting/dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No<br>an. Paralysis/weakness <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ao. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ap. Disorder of the brain/Alzheimer's <input type="checkbox"/> Yes <input type="checkbox"/> No<br>aq. Mental/Emotional/Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ar. Lungs <input type="checkbox"/> Yes <input type="checkbox"/> No<br>as. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No<br>at. Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No<br>au. Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No<br>av. Respiratory system <input type="checkbox"/> Yes <input type="checkbox"/> No<br>aw. Reproductive system <input type="checkbox"/> Yes <input type="checkbox"/> No<br>ax. Digestive system/stomach <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|
10. Are you currently taking any medication?  Yes  No
11. Has your weight changed in the past year?  Yes  No
12. Have you ever undergone a surgical operation?  Yes  No
13. Have you taken any other medicines in the past 12 months?  Yes  No
14. Have you any reason to believe that a surgical operation may be necessary in the future?  Yes  No
15. Have you ever suffered from any other conditions or injuries for which medical advice was sought?  Yes  No
16. Other than the medical conditions noted above, I am in good health.  Yes  No
17. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)?  Yes  No

Questions # \_\_\_\_\_ Dates & Details: \_\_\_\_\_

Questions # \_\_\_\_\_

Questions # \_\_\_\_\_

Questions # \_\_\_\_\_

Questions # \_\_\_\_\_

Questions # \_\_\_\_\_

Questions # \_\_\_\_\_

Questions # \_\_\_\_\_

**DECLARATION**

**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 health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctors to give 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 I have been treatment free for 24 months after inception.**



**PETERSEN INTERNATIONAL UNDERWRITERS**  
23929 Valencia Boulevard, Suite 215, Valencia, California 91355  
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Website: <http://www.piu.org> E-Mail: [piu@piu.org](mailto:piu@piu.org)

**AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION**  
**This Authorization complies with the HIPAA Privacy Rule**

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I 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, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/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, information and/or 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. 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.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Signature of Legal Representative (if other than Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

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

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