Application for
Pilot's Loss of License Disability Insurance

INTERNATIONAL
A division of Morgan White Group
3191 Coral Way, 7th Floor
Miami, Florida 33145

It is important that all sections of this proposal form should be fully completed even if it is for renewal of or for an amount additional to an existing insurance. You should declare all conditions even though you have been declared fit. You should not omit to mention investigations where you have been told that the result is satisfactory. Failure to disclose material information may invalidate the policy.

General Pilot Information

Surname	Rank	First Names	Date of Birth			Age	Height (ft/inch)	Weight (lbs)	
			Day	Mth	Year			Current	12 mo. ago

Address (Including City & State)	Telephone Number (Home and Work)

Annual Salary (Including Bonuses)

Employer	Type of Duties/Aircraft (please check all which apply)
	❑ Commercial ❑ Fixed Wing ❑ Private ❑ Rotor Wing ❑ Instruction

All Current Licenses Held (please specify type, number & country of issue)

Family or Personal Physician	
Name:	Name:
Address:	Address:
Phone:	Phone:

Permanent Total Disability Benefit Amount Selected ($200,000, $300,000, $400,000 $500,000, $600,000, $700,000, $800,000, $900,000, $1,000,000)	$

Mode of Payment

❑ Annual

❑ Semi Annual

Type of Payment

❑ Check ❑ Credit Card ❑ Wire Transfer

$15.00 fee applies for wire transfer • When paying a Credit Card, a Credit Card authorization form must accompany application.

Total Annual Premium:
Modal Factor (Semi Annual .55) x Annual Premium:
Modal Premium Due:

Please provide customer number if you are an existing client.

Customer Number:

Part I Questions		*Yes*	*No*
1. Has any applicant ever been advised to or received medical consultation, care, treatment or taken medication for: (Please circle each condition)			
a	Heart or circulatory system (including but not limited to infarction, high blood pressure, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins or arteries) and/or any other symptom regarding the circulatory system or heart, which if referred to a doctor would result in a diagnosis.	❑	❑
b	Respiratory system (including but not limited to deviated septum, sinusitis, polyps or cyst, asthma, bronchitis, emphysema, bronchiectasis, tuberculosis) and/or any other symptom regarding the respiratory system, which if referred to a doctor would result in a diagnosis.	❑	❑
c	Gastrointestinal system (including but not limited to gastro esophageal reflux, hiatal hernia, gastritis, gastric or duodenal ulcer, duodenitis, diverticulosis, diverticulitis, polyps, colitis, gallbladder diseases) and/or any other symptom regarding the gastrointestinal system, which if referred to a doctor would result in a diagnosis.	❑	❑
d	Urinary system (including but not limited to kidney diseases, stones, infections, urinary tract disease, bladder disorders, and prostate diseases) and/or any other symptom regarding the urinary system, which if referred to a doctor would result in a diagnosis.	❑	❑
e	Musculoskeletal system (including but not limited to back disorders, spinal cord disorders, rheumatism, arthritis/arthrosis, gout, lumbago, osteoporosis, deformity, herniated disc) and/or any other symptom regarding the musculoskeletal system, which if referred to a doctor would result in a diagnosis.	❑	❑
f	Neoplastic disorders, benign or malignant tumors (cancer)	❑	❑
g	Endocrine system (including but not limited to Hypophysis gland diseases, Thyroid, Parathyroid, Diabetes, Ovaries and Adrenal glands disorders) and/or any other symptom regarding the endocrine system, which if referred to a doctor would result in a diagnosis.	❑	❑
h	Sexually transmitted diseases or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex).	❑	❑
i	Female reproductive system (including but not limited to disorders of menstrual cycle, ovaries, uterus including cervix, endometriosis, pelvic inflammatory diseases, fallopian tubes, vagina, miscarriages, cesarean section). Breast disorders (including but not limited to fibrocystic diseases, tumor) and/or any other symptom regarding the female reproductive system or breast, which if referred to a doctor would result in a diagnosis.	❑	❑
j	Male reproductive system (including but not limited to prostate, testes, and penis) and/or any other symptom regarding the male reproductive system, which if referred to a doctor would result in a diagnosis.	❑	❑
k	Neurological system (including but not limited to convulsions, epilepsy, paralysis, Multiple Sclerosis, cerebral infarction, Alzheimer's disease, Dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.	❑	❑
l	Liver disorders (including but not limited to fatty liver, Cirrhosis, Hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.	❑	❑
m	Any skin disorders (including but not limited to acne, psoriasis, melanomas, and carcinomas).	❑	❑
n	Hematologic and Lymphatic system (including but not limited to anemia, leukemia, multiple myeloma, Waldenstrom's Macroglobulinemia, Spleen's disorders and other blood and coagulation disorders) and/or any other symptom regarding the Hematologic and Lymphatic system, which if referred to a doctor would result in a diagnosis.	❑	❑
o	Collagen's diseases (including but not limited to Rheumatoid Arthritis, Systemic Lupus Erythematosus, Scleroderma) and/or any other symptom regarding collagen diseases, which if referred to a doctor would result in a diagnosis.	❑	❑
2. Has any applicant:			
a	Had health examinations or routine medical check-ups?	❑	❑
	Had any abnormalities?	❑	❑
b	Been a patient in a hospital, clinic or sanatorium?	❑	❑
3. Is any applicant pregnant?		❑	❑
4. Has any applicant been recommended to undergo a surgery that is still pending?		❑	❑
5. Is any applicant currently taking any prescribed medication or under medical treatment? Has any applicant been advised of future treatment?		❑	❑
6. Has any applicant been or is any applicant currently addicted to drugs or alcohol? Has any applicant ever used or is any applicant using drugs not prescribed by a physician? Has any applicant been in or is any applicant currently in a rehabilitation program for addiction or substance abuse?		❑	❑
7. Has any applicant received treatment or been diagnosed for any disorders or conditions? Is any applicant taking prescribed medication for any condition not mentioned above?		❑	❑
8. Has any applicant been declined, postponed or rated in any way? Please give details.		❑	❑
9. Has any applicant been involved in the operation of an aircraft or involved in any hazardous sport? Please give details.		❑	❑

Main Insured Signature: _____ Initials: _____

Part II Details *Give Full Details Below*

If you answered "yes" to any of the questions in the previous page, please complete this form or indicate the required information below:

No.	Applicant's Name	Diagnosis, treatments, results	Date	Physician / Hospital Details

Part III Questions	Yes	No
1. Is this proposal for renewal of an additional amount to an existing insurance policy? (If yes, please list existing Policy No., amount insured, and the agent.)	❑	❑
2. Are you entitled to benefit from any other "Loss of License, Permanent Health or Aircrew" Disability Insurance?	❑	❑
3. Do you hold a current medical certificate?	❑	❑
4. Has any limitation or endorsement been imposed on any license you hold or have held?	❑	❑
5. Date of last Aircrew medical examination: _____ /_____ /_____		
6. Date of last electrocardiograph taken as required by the licensing authority: _____ /_____ /_____		
7. Were you advised of any abnormality in or revealed by the examination?	❑	❑
8. Have you ever been grounded or had any license invalidated for medical reasons?	❑	❑
9. Have you ever been required to take additional tests at or after medical examination, been referred for specialist investigation, had the issue or renewal of any medical certificate deferred, had to return for examination at less than the normal interval of time or been ordered to take drugs or follow any special diet or treatment?	❑	❑
10. Have you consulted any medical practitioner or attended hospital during the last FIVE years other than for the purpose of obtaining or renewing your license?	❑	❑

Medical History		Yes	No
All medical conditions must be stated giving all disabilities, illnesses and accidents, with appropriate dates. If you have no medical history to declare state none.			
Are you aware of any deterioration in your health including hearing, eyesight and blood pressure?		❑	❑
What is your average daily consumption of alcohol? _____			
Have you smoked cigarettes, cigars or a pipe in the last 12 months?		❑	❑
Has either of your parents or bothers or sisters had diabetes, heart disease, high blood pressure or a mental or nervous disease? (If so, please give full details, including approximate age at onset.)		❑	❑
Has any insurance company or underwriter:			
a	declined or deferred a Proposal from you?	❑	❑
b	charged or quoted more than standard rates?	❑	❑
c	cancelled or declined to renew your insurance?	❑	❑

Initials: _____

Beneficiary Designation	
All benefits are assigned to the designated beneficiary.	*In the event of death of beneficiary.*
Beneficiary:	*Contingent Beneficiary:*
Name:	**Name:**
Date of Birth:	Date of Birth:
Address:	Address:
Phone:	Phone:

Applicant's Statement

I hereby certify all responses and declarations contained in this application are true, complete and correct and I understand and agree any inaccuracy or omission in responses will constitute grounds for the insurer to deny a claim, invalidate or cancel any of the insurance coverage applied for. In the event the insurer cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history or Pre-existing conditions, the insurer reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand the broker, agent or agency receiving this application does not have the authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and all information requested in the application must be set forth in writing on this application. I further understand this application will become part of the insurance policy to be issued and the insurer will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand the broker, agent or agency taking this application from me is an independent representative and is acting on my behalf and not the administrator nor the insurance company offering this insurance. Neither the administrator nor the company offering this insurance can be held liable for any circumstance if the broker, agent or agency, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator.

It is understood the insurance applied for shall not become effective until this application is approved and accepted by the insurer, full payment of the first premium is made, and the policy issued, subject to all conditions and restrictions contained therein. I understand this policy is not available to permanent residents of the United States or others who reside in the United States. However, if any applicant for coverage, who is accepted and insured by the insurer in the applicant's country of residence, moves to the United States of America, the insurer will provide an option to continue insurance coverage.

Signature of Proposed Applicant _____ Date _____ /_____ /_____
Day Month Year

Medical Authorization

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering the insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering the insurance, and its reinsurers to determine eligibility. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

Signature of Proposed Applicant _____ Date _____ /_____ /_____
Day Month Year

I personally solicited and completed this application as given or the answers were made by the proposed insured in his or her own handwriting.
All medical and non-medical questions were asked of each proposed insured and their answers were recorded as given.

Agent Signature / Witness:_____Agent Code: _____

Agent Email: _____Date: _____

Mail completed, signed enrollment form to:

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