INTERNATIONAL
SPECIALTY INSURANCE, INC

HELPING PROTECT WHAT YOU'VE ACHIEVED

QUESTIONS?
800-849-0474

INSTRUCTIONS: Print in black and initial all changes. Answer all questions in their entirety. Any unanswered questions will delay the processing "N/A" or "None" are unsatisfactory answers and will not be accepted. Before any question is answered read carefully the declaration at the end of this proposal, which must be signed.

Pilot Disability Application

Loss of License – Temporary and Permanent

For Corporate Pilots, Cargo Pilots, Commercial Pilots, Agricultural Pilots, Fire ghter Pilots, Test Pilots, Air Ambulance Pilots

1. Proposed Insured:

FIRST NAME | M.I. | LAST NAME

ADDRESS

CITY | STATE | ZIP CODE

SOCIAL SECURITY NO.

GENDER: ☐ MALE ☐ FEMALE

WEIGHT: HEIGHT:

2. Date of Birth:

MM | DD | YYYY

Place of Birth:

3. Residence of Proposed Insured:

ADDRESS

CITY | STATE | ZIP CODE

4. Employer:

A. FLYING OCCUPATION: | SALARY/INCOME:

B. NON-FLYING OCCUPATION: | SALARY/INCOME:

5. Flight Category

☐ AIR SHOW PILOT ☐ TEST PILOT ☐ COMMERCIAL PILOT ☐ CORPORATE PILOT

☐ FIREFIGHTER PILOT ☐ CARGO PILOT ☐ AGRICULTURE PILOT ☐ AERIAL APPLICATOR

Aircraft Category:

☐ FIXED WING

☐ HELICOPTER

6. For which benefits are you applying?

PLEASE PROVIDE COPIES OF THE PAST 3 YEARS TAX RETURNS AS PROOF OF INCOME.

$ PER MONTH
MONTHLY DISABILITY BENEFITS:

$
PERMANENT TOTAL DISABILITY:

ELIMINATION PERIOD REQUIRED:

☐ 30 DAYS ☐ 60 DAYS ☐ 90 DAYS ☐ OTHER

$ MONTHS
MAXIMUM BENEFIT PERIOD REQUIRED:

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7. License

NUMBER OF YEARS LICENSED? _____ TOTAL # OF LIFETIME FLYING HOURS _____ TOTAL PAST 12 MONTHS? _____ TOTAL NEXT 12 MONTHS? _____

A. DATE OF LAST FAA MEDICAL EXAM: _____

B. DATE OF LAST BIENNIAL FLIGHT REVIEW (BFR): _____

CURRENT LICENSE HELD:

☐ FLIGHT INSTRUCTOR ☐ COMMERCIAL ☐ INSTRUMENT FLIGHT RATING ☐ ATP RATING ☐ ROTOCRAFT ☐ MULTI-ENGINE

8. Have you ever had any Life, Health or Accident insurance ever canceled or declined?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE REASON(S) FOR DECLINATION, SPECIAL TERMS AND/OR CONDITIONS: _____

9. Are you now insured against accident or illness by you or your employer?

☐ YES ☐ NO

IF YES, WITH WHOM AND WHAT AMOUNT AND WEEKLY BENEFITS? _____

10. Have you ever been grounded or had your license invalidated for medical reasons?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

11. Have any limitations ever been endorsed on your license?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

12. Are you aware of any deterioration in your general health, hearing, eyesight or blood pressure?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

13. Do you presently take any medications, over the counter or prescription medicine(s)?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

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14. Have you even been treated for or had any indication of:

A. Disorder of the eyes, ears, nose or throat?	☐ YES	☐ NO
B. Dizziness, fainting, convulsions or headache; speech defect paralysis or stroke; mental or nervous disorder?	☐ YES	☐ NO
C. Shortness of breath, persistent hoarseness, cough or bronchitis; pleurisy, asthma, emphysema, tuberculosis or lung disorder?	☐ YES	☐ NO
D. Chest pain, high blood pressure, stroke, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or circulatory systems?	☐ YES	☐ NO
E. Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, jaundice, or an other disease of the liver, gall bladder, pancreas, stomach or intestines?	☐ YES	☐ NO
F. Sugar, albumin, blood or pus in urine; nephritis, stone or other disorder of the kidney or bladder?	☐ YES	☐ NO
G. Disorder of the reproductive organs, prostate or testicular disease; or disease of the uterus, ovaries or breasts; complications of pregnancy?	☐ YES	☐ NO
H. Diabetes, thyroid, or other endocrine disorders?	☐ YES	☐ NO
I. Neuritis, sciatica, arthritis, gout, or disorder of the muscles or bones including the spine, back or joints	☐ YES	☐ NO
J. Disorder of the skin, lymph glands, cyst, tumor or cancer?	☐ YES	☐ NO
K. Allergies, anemia, leukemia or other blood disorder?	☐ YES	☐ NO

15. After or during a medical examination:

A. Have you ever been required to take additional test?.	☐ YES	☐ NO
B. Have you ever been referred to a specialist for an examination?	☐ YES	☐ NO
C. Have you ever had the issue or renewal of your medical certificate deferred?	☐ YES	☐ NO
D. Have you ever had to return for examination at less than the normal interval time?	☐ YES	☐ NO
E. Have you ever been ordered to take drugs or follow any specific diet?	☐ YES	☐ NO

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16. If you answered "YES" to questions 14 or 15, please provide details:

DECLARATION

To the best of my/our knowledge and belief, the information provided in connection with this proposal, whether in my/our own hand or not, is true and I/we have not withheld any material facts. I/We understand that non-disclosure or misrepresentation of a material fact may entitle Underwriters to the insurance. (N.B. a material fact is one likely to influence acceptance or assessment of this proposal by Underwriters. If you are in any doubt as to whether a fact is material or not, you must disclose it.) I/We understand that Underwriters will determine their terms and conditions upon the information provided in connection with this proposal; and I/we further understand that the signing of this proposal does not bind me/us to complete or Underwriters to accept this Insurance.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I, the Proposed Insured, declare that all responses made to each and every question in the Application are truce and complete. I understand that:

A. Any false statements or material misrepresentations shall result in the loss of coverage under any policy and/or certificate which may be in force and/or any coverage which are being offered; and

B. No representation made to or information possessed by any agent shall be binding on the Underwriters and/or the Insurer, unless disclosed in the Application.

Signature of Proposed Insured

Printed Name

Signature of Policy Owner (if not Proposed Insured)

Printed Name

Date

Signed at (City, State)

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AGENT STATEMENT

I certify that I have truly and accurately recorded all the information given to me by the applicant, and I certify that I know of no other medical information about the person applying for coverage other than that contained on this application. I certify that the applicant has either filled out the application or has personally reviewed the completed application. I have explained all policy benefits, exclusions and limitations.

Producing Agent's Signature

Producing Agent's Name (please print)

Date

Agency Name

AUTHORIZATION

To all physicians, medical professionals, hospitals, clinics, other health care providers, insurers, employers, Medical Information Bureau (MIB), consumer reporting agencies, other insurance support organizations, and other persons who have information about the proposed insured.

I authorize you to give the Insurer, its reinsurers, its agents all information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the proposed insured and any non-medical information, including any investigative consumer reports, which the company believes it needs to perform the business functions described below.

The information obtained will be used to determine if the Proposed Insured is eligible for the insurance requested; or benefits under a policy which is in force. It will also be used for any other business purpose which relates to the insurance requested or the policy which is in force.

The form will be valid for 36 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

Date

Signature of Proposed Insured

Printed Name of Proposed Insured

PLEASE RETURN COMPLETED FORMS TO:

INTERNATIONAL SPECIALTY INSURANCE
110 Oakwood Drive, Suite 420
Winston-Salem, NC 27103

PHONE: 336.835.2230 : FAX: 336.835.1729
www.isinsurance.com