



SETTLEMENT APPLICATION *(Please print or type)*

A. PERSONAL INFORMATION - INSURED

Name of Insured	Date of Birth	Social Security Number	Sex <i>(male/female)</i>
-----------------	---------------	------------------------	--------------------------

Name of 2 nd Insured	Date of Birth	Social Security Number	Sex <i>(male/female)</i>
---------------------------------	---------------	------------------------	--------------------------

Address	Phone Number
---------	--------------

City	State	Zip Code
------	-------	----------

B. MEDICAL INFORMATION

Insured Medical History _____

2nd Insured Medical History _____

Primary Physician	Telephone Number
-------------------	------------------

Specialist	Telephone Number
------------	------------------

C. PERSONAL INFORMATION – VIATOR/POLICY OWNER.

Is the insured also the viator/policy owner? No Yes

Complete if Viator/Policy Owner is an individual other than the insured.

Name of Viator/Policy Owner	Date of Birth	Social Security Number
-----------------------------	---------------	------------------------

Name of 2 nd Viator/Policy Owner	Date of Birth	Social Security Number
---	---------------	------------------------

Address	Phone Number
---------	--------------

City	State	Zip Code
------	-------	----------

Marital Status: Single/Never Married Married Divorced Separated Widow/Widower

If Married, Name of Spouse _____

Is the viator/policy owner a defendant in any suits or legal actions? No Yes

Has the viator/policy owner ever declared bankruptcy? No Yes

Drivers License #: _____	State of Issue: _____
--------------------------	-----------------------

SETTLEMENT APPLICATION, Page 2

Complete if Viator/Policy Owner is a Trust, Corporation, Partnership, LLC or Other Entity.

Name of Viator/Policy Owner		Tax ID Number
Name of Authorized Representative		Title (<i>Trustee, Corporate Officer, Partner, etc.</i>)
Address		Phone Number
City	State	Zip Code
State of Trust Situs, Incorporation, Formation or Domicile of Entity		

D. LIFE INSURANCE INFORMATION

Insurance Company	Policy Number	Face Amount
Date of Issue	Policy Type (<i>WL, UL, SUL, Term, etc...</i>)	Current Premium

Initial viator/policy owner (*at time of issuance*) Name of current viator/policy owner (*If different*)

Has policy beneficiary changed since the policy was issued? No Yes

If yes, please explain why.

Name of initial beneficiary(s) Relationship(s) to insured

Name of current beneficiary(s) (*If different*) Relationship(s) to insured

What was the insured's and viator/policy owner's original purpose for buying the policy?

Before or at the time the policy was issued, did the insured, viator/policy owner or any other party arrange to transfer, sell or assign, directly or indirectly the policy or any benefits to a third party? No Yes

If yes, describe the arrangement in detail and provide copies of documents relating to the arrangement.

Has the insured or viator/policy owner ever assigned the policy or policy benefits to any person or entity? No Yes

If yes, describe the details of such assignment.

Has the policy or any of the policy premiums been financed by a third party, either through a loan, equity contribution or otherwise? No Yes

If yes, please describe the financing arrangement in detail and provide copies of any document related to that arrangement.

SETTLEMENT APPLICATION, Page 3

If yes, what is name of lender? _____

Principal loan amount _____

Loan maturity balance (payoff amount) _____

Loan maturity date _____

List all persons or entities (including any trust) that have, or have had, any direct or indirect ownership or other interest in the policy or its proceeds, including the nature of the interest and the relationship of such person entity to the insured. For any entity, please identify all persons that own (or have owned) and, if different, control or manage (or have controlled or managed) that entity. For any trust, include all parties, including but not limited to: grantor(s), trustee(s), and beneficiary(ies).

Name nature of the interest date and manner interest was obtained relationship to insured

Name nature of the interest date and manner interest was obtained relationship to insured

Name nature of the interest date and manner interest was obtained relationship to insured

Name nature of the interest date and manner interest was obtained relationship to insured

For additional policy and/or physician information, please provide a supplementary page.

For Agent Use: If available, please include the following: 1) Current in force Illustration to maturity.
2) Current medical records/APS (if not within the last 90 days, please provide physician information in Section B).

The undersigned represents to Life Insurance Settlements, Inc. that:

- A. The information contained herein is complete and accurate and may be relied upon by Life Insurance Settlements, Inc., Viatical Settlement Providers and Financing Sources.
- B. The undersigned will immediately notify Life Insurance Settlements, Inc. of any material change in any information contained herein, occurring prior to conclusion of the proposed sale, including but not limited to: cancellation and release of insurance policies, assignment of ownership of policies, change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies.

The proposed sale, cancellation and release of insurance policies, assignment of ownership of policies, or change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies will be solely for the benefit and account of the undersigned, and not for the account or benefit of any other person.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A VIATICAL SETTLEMENT CONTRACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO APPLICANTS

Neither Life Insurance Settlements, Inc. nor its officers, directors, or principals provide legal, accounting, or financial advice to prospective applicants regarding the advisability or relative merits of selling or conveying their legal rights in existing life insurance policies in exchange for cash payments referred to as living benefits, viatical settlements, intervivos settlements, or other similar terms. An applicant must determine the relative benefit of any such living benefit settlement after review of the legal and financial implications of such a settlement with the applicant's own attorney, accountant, or other appropriate advisors, only then, should a decision be made to effect such a sale or settlement.

Applicant has a clear & complete understanding of the current or future benefits of the life insurance policy being offered for sale or settlement.

Applicant acknowledges that he/she has freely and voluntarily provided the information requested in this application.

PLEASE SEND WITH THE COMPLETE APPLICATION FORM, PHOTOCOPIES OF THE FOLLOWING:

- A. Life Insurance policy to be sold, including the application for insurance
- B. Your Driver's License
- C. Last premium statement from your Life Insurance company
- D. Social Security Card

In executing this application, each insured acknowledges and agrees that, subject to all applicable laws (including privacy laws), Life Insurance Settlements, Inc. shall have the right (regardless of whether or not a settlement transaction is completed) to license, sell and assign all data and information submitted or collected in connection with the potential settlement transaction, as well as all rights under the accompanying Authorization For Disclosure of Protected Health Information authorizing the disclosure of the insured's protected health information, to a third party financial institution, which may use such data or information to: (a) track performance of life expectancy underwriters; and (b) develop and use indices related to actual and anticipated longevity, mortality, life expectancies and/or similar measures of human lives in a manner in which the identity of underlying individuals may not be personally identified.

VIATOR/POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

VIATOR/POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

*This signature page may be duplicated if there are more than two (2) viator/ policy owners.
Two (2) witnesses are required if there is more than one (1) policy owner and/or more than one (1) insured.*



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (*Name of Individual*), authorize disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“PHI”) as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an “HCP”) having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photo static or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Life Insurance Settlements, Inc. and any of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an “Authorized Recipient”).

3. Protected Health Information Authorized for Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This information may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

4. Purpose of Disclosure: This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore, that Life Insurance Settlements, Inc. brokers.

5. Expiration: I understand this authorization will remain in effect for a maximum of one (1) year from the date of signature or until the specific date of _____.

6. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION,

Page 2

7. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

Signature of Individual: _____ **Date:** _____

Printed Name of Individual: _____

Date of Birth: _____ **SSN:** _____

If the individual has an appointed personal representative, please sign below.

Signature of Representative: _____ **Date:** _____

Printed Name of Representative: _____

Description of Personal Representative's Authority:

(For example: Power of Attorney, Guardian ad Litem or similar status. Please attach a copy any official document confirming this status.)



LIFE INSURANCE INFORMATION RELEASE FORM

Policy Owner: _____

Insured: _____

Policy Number: _____

Insurance Carrier: _____

I hereby authorize my insurance company to furnish Life Insurance Settlements, Inc. (LIS) and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, with any information, verbal or written, including any illustrations, verification of coverage, forms, copies of riders or amendments in connection with any life insurance policy under which my life is insured (including any conversions or replacements).

I authorize LIS to share this information with viatical settlement providers, viatical settlement brokers, and other parties, as required. The purpose of this sharing of information is to obtain quotes for viatical settlements.

I specifically authorize and request my insurance company and each authorized discloser, viatical settlement broker, and viatical settlement provider to rely upon a photo static or facsimile copy or other reproduction of this authorization as valid as the original.

I agree and acknowledge this authorization shall remain valid for one (1) year after the date of signature.

POLICY OWNER

Signature: _____

Printed Name: _____

SSN/Tax ID: _____

Date: _____

POLICY OWNER

Signature: _____

Printed Name: _____

SSN/Tax ID: _____

Date: _____



DISCLOSURE

The owner of the life insurance policy to be viaticated, the viator, should be aware of the following:

1. That there are possible alternatives to contracts including any accelerated death benefits or policy loans offered under the viator's policy.
2. That some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.
3. That the proceeds of the viatical settlement could be subject to the claims of creditors.
4. That receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
5. The viatical settlement provider company, not the viator, may compensate LIS based on a formula that is a percentage of the face value of the life insurance policy. For example, compensation for a \$100,000 policy could be: $8\% \times \$100,000$ (face value) = \$8,000.00. Life Insurance Settlements, Inc. hereby certifies that the brokers named will not be employed by the Viatical Settlement Providers involved in the transaction.
6. That the viator has the right to rescind a contract for ten (10) business days after the receipt of the viatical settlement proceeds by the viator, as provided by North Carolina law. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the provider or purchaser.
7. That funds will be sent to viator within three (3) business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
8. That entering into a contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator, and that assistance should be sought from a financial adviser.
9. That all medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share every two years.
10. That the insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three (3) months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

DISCLOSURE, Page 2

I have received the most current form of brochure describing the process of viatical or life settlements prepared by the National Association of Insurance Commissioners and provided as part of the viatical settlement disclosure.

VIATOR/POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

VIATOR/POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

*This signature page may be duplicated if there are more than two (2) policy owners.
Two (2) witnesses are required if there is more than one (1) policy owner and/or more than one (1) insured.*



BROKER AUTHORIZATION & SERVICES AGREEMENT

As one of the major firms in the settlement industry brokering life policies, Life Insurance Settlements, Inc. and its staff of experienced and trained professionals continually strive to set the standards nationwide in the areas of corporate responsibility, professionalism, adherence to compliance and regulatory issues, and the highest ethical treatment of clients and business associates. We represent the best interests of our clients and maximize the sales value of their policy (ies) in the secondary market. As your designated viatical settlement broker, Life Insurance Settlements, Inc. incurs the necessary, required and related costs to facilitate your viatical settlement transaction while providing the following services including but not limited to:

- Evaluation Form assessment.
- Medical underwriting and insurance verifications.
- Obtaining and forwarding independent third party life expectancy reports.
- Submission to multiple authorized and /or registered life settlement providers.
- Best execution negotiation to maximize fair market value for a viatical settlement.
- Closing services including contract review and assistance with contingency requirements of viatical settlement providers.

In consideration of the services provided and related costs incurred as described above, I/We authorize Life Insurance Settlements, Inc. to act as my/our viatical settlement broker and to evaluate, underwrite, solicit, generate and secure offers beginning on the date of execution of the Agreement and continuing for 365 days, or one calendar year, whatever is longer after the final offer is obtained/acquired regarding and/or related to the purchase of the following life insurance policy (ies) for the insured(s)

_____:

Life insurance policy number _____ issued by _____

Life insurance policy number _____ issued by _____

Life insurance policy number _____ issued by _____

By signing this authorization and agreement, I/we am/are aware:

1. Committing for the period of time described above to Life Insurance Settlements, Inc. and to no other individual or entity, including but not limited to any viatical settlement broker, producer and financial advisor, to evaluate, underwrite, solicit, generate and secure conditional and appropriate offers, as determined by Life Insurance Settlements, Inc. pursuant to its typical business model, methods and practices, for the sale of my/our life insurance policy (ies) as state above.
2. Recognizing the proprietary nature of such appropriate, conditional offers as evaluated, underwritten, solicited, generated and secured by Life Insurance Settlements, Inc. for the period of time as described above and pursuant to this Broker Authorization & services Agreement.

In all respects in connection with the transaction, the viatical settlement broker, Life Insurance Settlements, Inc. will act exclusively on behalf of the Viator/Policy Owner and the Insured, and owes duties to the Viator/Policy Owner and the Insured, and has not acted on behalf of, and owes no duties to, the Viatical Settlement Provider or its successors or permitted assigns.

BROKER AUTHORIZATION & SERVICES AGREEMENT, Page 2

The Viatical Settlement Broker, Life Insurance Settlements, Inc. will use its best efforts, on behalf of the Viator/Policy Owner, to obtain the most favorable terms and conditions for the Viator/Policy Owner in respect of the sale of the Policy, including, without limitation, the best price for the Policy. Life Insurance Settlements, Inc. issues no guarantee that the life insurance policy will be sold, and is under no obligation to purchase the policy or to ultimately find a Viatical Settlement Provider for the policy(ies) and is not responsible for any breach committed by a Viatical Settlement Provider, if such Viatical Settlement Provider is identified.

I/We understand that Life Insurance Settlements, Inc. has a duty to find the most competitive offer available for my/our life insurance policy (ies). Therefore, I/we hereby grant to Life Insurance Settlements, Inc. the exclusive right to broker my/our life insurance policy(ies) which may only be terminated upon thirty (30) days prior written notice. Prior to making the decision to sell the Policy, I/We have had the opportunity to discuss any questions about the transaction with other appropriate professionals such as my/our lawyer, accountant and tax advisor.

VIATOR/POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

VIATOR/POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

VIATICAL SETTLEMENT BROKER

Signature: _____

Printed Name: _____

Title: _____

Date: _____