SETTLEMENT APPLICATION (PLEASE PRINT OR TYPE)

A. PERSONAL INFORMATION - INSURED

Name of Insured | Date of Birth | Social Security Number | Sex (*male/female*)

Name of 2nd Insured | Date of Birth | Social Security Number | Sex (*male/female*)

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 – POLICY OWNER. Complete if Policy Owner is an individual other than insured.

Name of Policy Owner | Date of Birth | Social Security Number

Name of 2nd 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 policy owner a defendant in any suits or legal actions? ☐ No ☐ Yes
Has the policy owner ever declared bankruptcy? ☐ No ☐ Yes
Drivers license # _____ State of Issue_____

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

Name of Policy Owner | Tax ID Number

Name of Authorized Representative | Title (*Trustee, Corporate Officer, Partner, etc*.)

Address | Phone Number

City | State | Zip Code

Trust Situs/ State of Incorporation or Domicile

D. LIFE INSURANCE INFORMATION

Insurance Company | Policy Number | Face Amount

Date of Issue | Policy Type (*WL, UL, SUL, Term, etc…)* | Current Premium

Initial policy owner (*at time of Issuance*) | Name of current 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 policy owner's original purpose for buying the policy? _____

Before or at the time the policy was issued, did the insured, 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 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. _____

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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 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., Life Settlement/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 LIFE SETTLEMENT/VIATICAL SETTLEMENT CONTRACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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NOTICE TO APPLICANTS

Neither Life Insurance Settlements, Inc. nor it's 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.

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

LIFE INSURANCE 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.

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.

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

SSN/Tax ID: _____

Date: _____

LIFE INSURANCE 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. There are possible alternatives to viatical settlement contracts, including any accelerated death benefits or policy loans offered under the viator's life insurance policy;

2. Some or all of the proceeds of the viatical settlement contract may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor;

3. Proceeds of the viatical settlement contract could be subject to the claims of creditors;

4. Receipt of the proceeds of a viatical settlement contract 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 viator has the right to rescind a viatical settlement contract before the earlier of 30 calendar days after the date upon which the settlement contract is executed by all parties or 15 calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in subsection c. of section 9 of this act. If exercised by the viator, rescission is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans and loan interest to the settlement provider is made within the rescission period. If the insured dies during the rescission period, the viatical 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 viatical settlement provider;

6. Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy has been transferred and the beneficiary has been designated pursuant to the viatical settlement contract;

7. 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 could be: 8% x $100,000 (face value) = $8,000.00).* However, compensation will not exceed the settlement proceed amount to the policy owner;

8. Entering into a viatical settlement 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. All medical, financial or personal information solicited or obtained by a viatical settlement provider or life insurance producer 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 viatical settlement 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 information every two years;

DISCLOSURE, Page 2

10. The insured may be contacted by the viatical settlement provider or its authorized representative for the purpose of determining the insured's health status. This contact shall be limited to once every three 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;

11. 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.

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED

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.