



**VIATICAL SETTLEMENT APPLICATION**

**A. PERSONAL INFORMATION - INSURED (PRINT OR TYPE)**

Name of Insured: \_\_\_\_\_  Male  Female  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Marital Status:  Single/Never Married  Married  Divorced  Separated  Widow/Widower  
If Married, Name of Spouse: \_\_\_\_\_ Dependent Children?  Yes  No

**Complete for Second Insured, if applicable.** Is the Second Insured deceased?  Yes  No

Name of Insured: \_\_\_\_\_  Male  Female  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Marital Status:  Single/Never Married  Married  Divorced  Separated  Widow/Widower  
If Married, Name of Spouse: \_\_\_\_\_ Dependent Children?  Yes  No

**B. MEDICAL INFORMATION**

Medical History of Insured: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Specialist: \_\_\_\_\_ Telephone number: \_\_\_\_\_

**Complete for Second Insured, if applicable.**

Medical History of Insured: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Specialist: \_\_\_\_\_ Telephone number: \_\_\_\_\_

*For additional medical or physician information, please provide a supplementary page.*

**C. LIFE INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Date of Issue: \_\_\_\_\_

Policy Type:  Term  UL  WL  SUL  SWL  VUL  Other: \_\_\_\_\_

Annual Premium Amount: \_\_\_\_\_ Premium Due Date: \_\_\_\_\_

Last Premium Paid Date: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

**D. PERSONAL INFORMATION – VIATOR/POLICY OWNER**

Is the Insured also the Policy Owner?  Yes  No

If yes, please answer the following and move to page 3. If no, please proceed to section E or F accordingly.

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

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

**E. Complete if Viator/Policy Owner is an Individual**

Name of Viator/Policy Owner: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

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?  Yes  No

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

**F. Complete if Viator/Policy Owner is Trust, Corporation, Partnership, or Other Entity.**

Name of Viator/Policy Owner: \_\_\_\_\_

Name of Authorized Representative and Title: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_ State of Formation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

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

**VIATICAL SETTLEMENT APPLICATION, Page 3**

**Please complete the following questions.**

1. Has the Viator/Policy Owner changed since the policy was issued?  Yes  No

If yes, please list name of initial Viator/Policy Owner: \_\_\_\_\_

2. Name of current Beneficiary: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

3. Has Beneficiary changed since the policy was issued?  Yes  No

If yes, please list name of initial Beneficiary: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

4. What was the Insured's and Viator/Policy Owner's original purpose for buying the policy? Explanations such as "estate planning" should be expanded upon.

\_\_\_\_\_  
\_\_\_\_\_

5. 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?  Yes  No

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

\_\_\_\_\_  
\_\_\_\_\_

6. Has the Insured or Viator/Policy Owner ever assigned the policy or policy benefits to any person or entity?

Yes  No If yes, describe the details of such assignment.

\_\_\_\_\_  
\_\_\_\_\_

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

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

\_\_\_\_\_  
Name of Lender: \_\_\_\_\_

Principal loan amount: \_\_\_\_\_

Loan Maturity balance (*payoff amount*): \_\_\_\_\_ Loan Maturity date: \_\_\_\_\_

**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., and all Viatical Settlement Providers licensed in New Mexico where the viatical settlement case may be submitted for review.
- 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 and 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. Copy of Life Insurance Policy to be sold, including the application for insurance
- B. Copy of Insured and Policy Owner Picture ID
- C. Copy of Social Security Card
- D. Last Premium Statement from your life insurance company (if available)

***Signature page to follow.***

**VIATICAL SETTLEMENT APPLICATION, Page 5**

The undersigned acknowledges they have read and fully understand this viatical settlement application.

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WITNESS**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSURED (if other than the viator/policy owner)**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WITNESS**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WITNESS**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSURED (if other than the viator/policy owner)**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WITNESS**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

*This signature page may be duplicated if there are more than two (2) policy owners.*

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION



A. Patient's Name <i>(please print)</i> :	Date of Birth: ____/____/____ Month Day Year	Medical Record Number (if known):
Address:	Telephone Number	Social Security Number (last 4 digits):

**B. Permission to Share:** I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

<b>Released From:</b>  Name: _____ Address: _____  Telephone: _____ Fax: _____	<b>Released To:</b>  Life Insurance Settlements, Inc. 1180 SW 36 <sup>th</sup> Avenue, Suite 201 Pompano Beach, FL 33069 Telephone 1-866-326-5433
--------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

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.

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION, Page 2**

5. Expiration: This authorization to disclose personal health information shall remain valid for twenty-four (24) months following the date of signature. If authorization shall remain valid for a specific length of time that is less than twenty-four (24), please specify the expiration date: \_\_\_\_\_.

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.

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 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. A copy of this authorization is as valid as the original.

**PATIENT OR INDIVIDUAL**

**SENSITIVE INFORMATION** - I understand and agree to the disclosure of the following information by placing my initials:

Signature: \_\_\_\_\_

\_\_\_\_\_ Mental Health Records

Printed Name: \_\_\_\_\_

\_\_\_\_\_ Drug & Alcohol Treatment Records

Date: \_\_\_\_\_

\_\_\_\_\_ HIV/AIDS Records

**PERSON AUTHORIZED TO SIGN ON BEHALF OF PATIENT OR INDIVIDUAL**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**For example: Power of Attorney, Guardian ad Litem or similar status. Please attach a copy any official document confirming this status. Not to be signed by an insurance agent, attorney, or financial representative.**



**LIFE INSURANCE INFORMATION RELEASE FORM**

Policy Owner:	_____
Insured:	_____
Policy Number:	_____
Insurer:	_____

I hereby authorize my insurance company to furnish Life Insurance Settlements, Inc. and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("LIS"), with any information, forms, 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, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for life settlements, and/or life and health insurance policies.

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.

Please accept this release form in lieu of any third-party authorization form the insurer may have.

I agree and acknowledge this authorization shall remain valid for one year after the date signed.

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

SSN/Tax ID: \_\_\_\_\_

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

SSN/Tax ID: \_\_\_\_\_





## **DISCLOSURE TO VIATICAL SETTLEMENT APPLICANT**

**(To be provided no later than at time of application for any viatical settlement agreement)  
(With acknowledgement of viatical settlement broker)**

**IMPORTANT – READ THIS DISCLOSURE FORM AND THE ENCLOSED VIATICAL SETTLEMENT INFORMATION BROCHURE BEFORE SIGNING ANY VIATICAL SETTLEMENT AGREEMENT. You should carefully read all of the following points and seek financial, insurance, tax and other advice where appropriate.**

1. That there are possible alternatives to viatical settlement contracts for persons with catastrophic, life- threatening or chronic illnesses, including any accelerated death benefits offered under the viator's life insurance policy;
2. That some or all of the proceeds of the viatical settlement may be free from federal income tax and from state franchise and income taxes, and that assistance should be sought from a professional tax adviser;
3. That the viator has a right to rescind a viatical settlement contract within fifteen calendar days after receipt of the viatical settlement proceeds;
4. That money will be sent to the viator within two 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 pursuant to the viatical settlement contract;
5. That proceeds of the viatical settlement could be subject to the claims of creditors;
6. 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 that advice should be obtained from the appropriate government agencies; and
7. That 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 or certificate, to be forfeited by the viator and that assistance should be sought from a financial adviser.
8. Contacts with the viator or insured for the purpose of determining the health status of the insured by the provider or broker after the viatical settlement has occurred shall only be made by the provider or broker licensed in New Mexico and shall be limited to once every three months for insureds with a life expectancy of more than one year and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured under a viaticated policy for reasons other than determining the viator's health status.

**DISCLOSURE TO VIATICAL SETTLEMENT APPLICANT, Page 2**

9. Except as otherwise allowed, a provider, broker, insurance company, insurance agent, insurance broker, information bureau, rating agency or company or any other person with actual knowledge of a viator's or insured's identity shall not disclose that identity to any other person unless the disclosure is:
- (a) necessary to effect a viatical settlement between the viator and a provider and the viator has given written consent and, if the insured's identity is being disclosed and the insured is competent, the insured has given written consent to the disclosure;
  - (b) provided in response to an investigation by the superintendent or any other governmental officer or agency; or
  - (c) a term of or condition to the transfer of a viaticated policy by one provider to another provider.
10. The viatical settlement provider company, not the policy owner, 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 \$100,000.00 policy could be:  $8\% \times \$100,000.00$  (face value) = \$8,000.00. The amount and method of calculation will be disclosed to the policy owner prior to execution of a viatical settlement contract. Life Insurance Settlements, Inc. hereby certifies that the brokers named will not be employed by the viatical settlement providers involved in the transaction.

**LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT: I have read and fully understand this disclosure form. I have received copies of this disclosure form and NAIC consumer brochure 'Selling Your Life Insurance Policy' to keep for my records.**

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**VIATICAL SETTLEMENT BROKER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

*This signature page may be duplicated if there are more than two (2) viator/policy owners.*



## **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 life 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 viatical settlement providers.
- Best execution negotiation to maximize fair market value of 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 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) \_\_\_\_\_:

Policy number \_\_\_\_\_ Issued by \_\_\_\_\_

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 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 Broker, Life Insurance Settlements, Inc. will act exclusively on behalf of the Seller and the Insured, and owes duties to the Seller and the Insured, and has not acted on behalf of, and owes no duties to, the Purchaser or its successors or permitted assigns.

**BROKER AUTHORIZATION & SERVICES AGREEMENT, Page 2**

The Broker, Life Insurance Settlements, Inc. will use its best efforts, on behalf of the Seller, to obtain the most favorable terms and conditions for the Seller 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.

**The undersigned acknowledges they have read and accept receipt of a copy of this Broker Authorization & Services Agreement.**

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**VIATOR/LIFE INSURANCE POLICY OWNER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSURED (if other than the policy owner)**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSURED (if other than the policy owner)**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**VIATICAL SETTLEMENT BROKER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_