LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market

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.

_____ Viator Initials _____ Viator Initials

VIATICAL SETTLEMENT APPLICATION, Page 2

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

_____ _____

Viator Initials Viator Initials

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: _____

_____ Viator Initials

_____ Viator Initials

VIATICAL SETTLEMENT APPLICATION, Page 4

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 Kansas 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 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 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.

Viator Initials _____ Viator Initials _____

VIATICAL SETTLEMENT APPLICATION, Page 5

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

LIFE INSURANCE POLICY OWNER (VIATOR)

Signature: _____

Printed Name:_____

Date: _____

LIFE INSURANCE POLICY OWNER (VIATOR)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name:_____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

INSURED (if other than the viator/policy owner)

Signature: _____

Printed Name:_____

Date: _____

INSURED (if other than the viator/policy owner)

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.

_____ Viator Initials

_____ Viator Initials

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market
1180 SW 36th Avenue, Suite 201
Pompano Beach, FL 33069

A. Patient's Name (*please print*):	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.

Released From:	**Released To:**
Name: _____ Address: _____ _____ Telephone: _____ Fax: _____	Life Insurance Settlements, Inc. 1180 SW 36th 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. All medical information solicited or obtained shall be subject to the applicable provisions of state law relating to confidentiality of medical information. 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

Signature: _____

Printed Name:_____

Date: _____

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

_____ Mental Health Records

_____ Drug & Alcohol Treatment Records

_____ 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 SETTLEMENTS INC
Financial Options for the Secondary Market

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 viatical 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.

LIFE INSURANCE POLICY OWNER (VIATOR)

Signature: _____

Printed Name:_____

Date: _____

SSN/Tax ID: _____

LIFE INSURANCE POLICY OWNER (VIATOR)

Signature: _____

Printed Name: _____

Date: _____

SSN/Tax ID: _____

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market

DISCLOSURE TO VIATICAL SETTLEMENT APPLICANT

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. 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. That a viatical settlement broker represents exclusively the viator and not the insurer or the viatical settlement provider. Furthermore, the viatical settlement broker owes a fiduciary duty to the viator including the duty to act according to the viator's instructions and in the best interest of the viator.
3. 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.
4. Proceeds of the viatical settlement could be subject to the claims of creditors.
5. 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.
6. The viator has the right to rescind a viatical settlement contract for 15 calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in subsection (c) of K.S.A. 2019 Supp. 40-5009a, and amendments thereto. 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 viatical settlement provider or purchaser.
7. 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 or interest in the certificate has been transferred and the beneficiary has been designated.
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 or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.
9. A viatical settlement broker shall disclose to a prospective viator the amount and method of calculating the broker's compensation. The term "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy. The viatical settlement provider company, not the owner, may compensate the viatical settlement broker 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% x $100,000 (face value) = $8,000.00.
10. Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The form for the brochure shall be developed by the commissioner.
11. All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement 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 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.

Viator Initials _____ Viator Initials _____

DISCLOSURE TO VIATICAL SETTLEMENT APPLICANT, Page 2

12. The insured may be contacted by either the viatical settlement provider or viatical settlement broker or such viatical settlement provider's or viatical settlement broker's authorized representative for the purpose of determining the insured's health status. This contact is 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.

VIATOR (LIFE INSURANCE POLICY OWNER) ACKNOWLEDGMENT: By signing below, the policy owner (viator) affirms that they were provided this disclosure document along with the NAIC brochure entitled "Selling Your Life Insurance Policy - Understanding Viatical Settlements". The viator (policy owner) affirms that they have read the above disclosures and referenced brochure.

VIATOR (LIFE INSURANCE POLICY OWNER)

Signature: _____

Printed Name:_____

Date: _____

VIATOR (LIFE INSURANCE POLICY OWNER)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name:_____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

INSURED (if other than the viator)

Signature: _____

Printed Name:_____

Date: _____

INSURED (if other than the viator)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name:_____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

VIATICAL SETTLEMENT BROKER

Signature: _____

Printed Name: _____

Title: _____

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) viator/policy owner and/or more than one (1) insured.

_____ _____
Viator Initials Viator Initials

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. Your designated viatical settlement broker 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 Peter M. Gaynor and the authorized representative 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 Peter M. Gaynor and the authorized representative 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 Peter M. Gaynor and the authorized representative 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 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.

_____ Viator Initials _____ Viator Initials

BROKER AUTHORIZATION & SERVICES AGREEMENT, Page 2

The broker 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. Peter M. Gaynor and the authorized representative 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 Peter M. Gaynor and the authorized representative 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 Peter M. Gaynor and the authorized representative 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.

LIFE INSURANCE POLICY OWNER (VIATOR)

Signature: _____

Printed Name:_____

Date: _____

LIFE INSURANCE POLICY OWNER (VIATOR)

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: _____

_____ _____

Viator Initials Viator Initials