

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 _____

PERSONAL INFORMATION POLICY OWNER – If a Trust, Corporation, Partnership, LLC or Other Entity

Trust Situs/ State of Incorporation or Domicile

Name of Signatory

Title (Trustee, Corporate Officer, Partner, etc.)

Name of Signatory

Title (Trustee, Corporate Officer, Partner, etc.)

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 the reason.

Name of initial beneficiary(s)

Relationship(s) to insured

Name of current beneficiary(s) (If different)

Relationship(s) to insured

1. What was the insured's and policy owner original purpose for buying the policy?

2. 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.

3. 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.

4. 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.

If yes, what is name of lender? _____ Principal loan amount _____
Loan Maturity balance (payoff amount) _____ Loan Maturity date _____

5. List all persons or entities (including any trust) who 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 beneficiaries.

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.

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 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.

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, life 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. Life Insurance policy to be sold, including the application for insurance
- B. Last premium statement from your Life Insurance company (if available)
- C. Driver's License of Insured and Policy Owner
- D. Social Security Card of Insured

The undersigned acknowledges they have read and understand this Life Settlement application. This application was signed and witnessed in the County of _____, State of _____.

Printed Name of Policy Owner Date

Signature of Policy Owner Date

Printed Name of Policy Owner Date

Signature of Policy Owner Date

Printed Name of Witness Date

Signature of Witness Date

Printed Name of First Insured Date

Signature of First Insured Date

Printed Name of Second Insured Date

Signature of Second Insured Date

Printed Name of Witness Date

Signature of Witness Date



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, 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 and Purpose of 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 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.

4. Expiration: This authorization shall remain valid until, and shall expire, one year after the date of my death.

5. 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.

6. 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.



LIFE INSURANCE INFORMATION RELEASE FORM

Policy Owner: _____
Insured: _____
Policy Number: _____
Insurance Carrier: _____

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 life settlement providers, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for life/viatical settlements, and/or life and health insurance policies.

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

Signature of Policy Owner

Date

Printed Name of Policy Owner

Social Security Number/Tax ID #

Signature of Policy Owner
(If more than one owner)

Date

Printed Name of Policy Owner

Social Security Number/Tax ID #



DISCLOSURE

IMPORTANT – READ THIS DISCLOSURE FORM BEFORE SIGNING ANY LIFE SETTLEMENT CONTRACT. Make sure you understand the facts. It is important that you read the following information.

1. Always check to see if there are possible alternatives to selling your policy. For example, check your insurance policy to see if you have an accelerated death benefit rider.
2. The life settlement proceeds may be subject to the claims of creditors.
3. Some or all of the proceeds of the life settlement may be taxable, and that assistance should be sought from a professional tax advisor.
4. Receipt of life settlement proceeds may affect your eligibility for Medicaid or other government benefits.
5. Your life insurance policy may have additional benefits such as coverage for long-term care, and may even be additional family members insured. Review your policy and be sure you are aware of all the benefits included before you decide to sell the policy and risk the loss of the additional benefits.
6. You have the option to cancel the life settlement contract within 30 days after the contract is signed by all parties, or within 15 days after you receive the proceeds.
7. You will receive the proceeds from the life settlement within 3 days after the change of ownership and beneficiary has been completed.
8. The insured may be contacted once every 3 months to verify the insured's health status and address.
9. The insured's private information may be provided to someone who buys the policy or provides the funds for the purchase.
10. Selling the life insurance policy of an insured may limit the amount of life insurance the insured will be able to purchase in the future.
11. The life settlement provider company, not the policy owner, may compensate Life Insurance Settlements, Inc. based on a formula that is a percentage of the offer obtained, not the face value of the policy. Life Insurance Settlements will disclose to the owner anything of value or given to LIS which relates to the life settlement contract.

DISCLOSURE, Page 2

The undersigned acknowledge they have read and received a copy of this Disclosure form and a copy the Kentucky Consumer Guide to Understanding Life Settlements.

Signature of Insured **Date**

Printed Name of Insured **Date**

Signature of 2nd Insured **Date**

Printed Name of 2nd Insured **Date**

Signature of Witness **Date**

Printed Name of Witness **Date**

Signature of Policy Owner **Date**

Printed Name of Policy Owner **Date**

Signature of 2nd Policy Owner **Date**

Printed Name of 2nd Policy Owner **Date**

Signature of Witness **Date**

Printed Name of Witness **Date**

Signature of Life Settlement Broker **Date**

Printed Name of Life Settlement Broker **Date**



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 life settlement transaction while providing the following services including but no 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 of life settlement.
- Closing services including contract review and assistance with contingency requirements of life 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.

