



LIFE SETTLEMENT APPLICATION

A. PERSONAL INFORMATION (PLEASE PRINT OR TYPE)

Name of Insured: _____ ☐ Male ☐ Female

Date of Birth: _____ SSN: _____

Name of 2nd Insured: _____ ☐ Male ☐ Female

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

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

B. LIFE INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____

Face Amount: _____ Date of Issue: _____

Policy Type: ☐ Term ☐ UL ☐ WL ☐ SUL ☐ SWL ☐ VUL ☐ Other: _____

Is the Insured also the Policy Owner? ☐ Yes ☐ No

Name of Policy Owner: _____

Authorized Representative if Entity or Trust: _____

SSN or Tax ID Number: _____ Relationship to Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

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

Name of Beneficiary: _____ Relationship to Insured: _____

C. MEDICAL INFORMATION

Medical History of Insured: _____

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Complete for 2nd Insured, if applicable.

Medical History of Insured: _____

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

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

LIFE SETTLEMENT APPLICATION, Page 2.

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE 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.

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

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

INSURED (if other than the policy owner)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

INSURED (if other than the policy owner)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

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.

Released From: Name: _____ Address: _____ Telephone: _____ Fax: _____	Released To: Life Insurance Settlements, Inc. 1180 SW 36 th Avenue, Suite 201 Pompano Beach, FL 33069 Telephone 1-866-326-5433
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I, _____ (**Name of Patient**), 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"), reproductive health care, mental health care (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

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

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 life 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, 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.

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

Signature: _____

Printed Name: _____

Date: _____

SSN/Tax ID: _____

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

SSN/Tax ID: _____



POLICY OWNER AUTHORIZATION

Policy Owner: _____

Insured: _____

Policy Number: _____

Insurer: _____

Re: Authorization for requests of information

To Whom It May Concern:

Please accept this letter as authorization for Life Insurance Settlements, Inc. to request information relating to the life insurance policies referenced above. The requested information may include, but is not limited to, requests for confirmation of ownership and beneficiary information, verification of policy values, premium payments and illustrations.

Please note that this letter does NOT authorize Life Insurance Settlements, Inc. to make any changes relating to the policy, such as change of ownership, change of beneficiary, or any other assignment or lien against the policy.

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

This authorization shall remain valid for thirty (30) months from the date it is signed.

Authorized personnel at Life Insurance Settlements, Inc. include:

Peter Gaynor	President
John Haynie, Jr	Vice President
James Nutt	Secretary
Loretta Kaplan	Treasurer, Operations Manager, Director of Contract Services
Daxton Fryer	Senior Analyst
Craig Campbell	Senior Analyst
Gage Gaynor	Analyst
Gibson Nutt	Analyst
Jack Carlton	Analyst
Mark Mrky	Senior Analyst
Oleg Eydelman	Senior Analyst
Nicole Lee	Senior Case Manager, Contract Services
AnnMarie Partis	Senior Case Manager
David Cooper	Senior Case Manager

Signature: _____ (Policy Owner)

Printed Name: _____

Date: _____



REQUIRED DISCLOSURES TO POLICY OWNER

IMPORTANT

READ THIS DISCLOSURE DOCUMENT BEFORE SIGNING A LIFE SETTLEMENT CONTRACT.

You should carefully read the following information and seek financial, insurance, tax and other advice where appropriate.

1. You, the owner, or the insured may have possible alternatives to life settlement contracts, such as accelerated death benefits or policy loans offered by the issuer of the life insurance policy.
2. **A life settlement broker represents exclusively, you, the owner, and not the insurer, the life settlement provider or any other person, and owes a fiduciary duty to you, including a duty to act according to your instructions and in your best interest.**
3. Some or all of the proceeds of a life settlement contract may be taxable under federal and state law. You should seek advice from a professional tax advisor.
4. Proceeds from a life settlement contract could be subject to the claims of creditors.
5. Receipt of the proceeds from a life settlement contract may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements, and advice should be obtained from the appropriate agencies.
6. A change of ownership of a life insurance policy could limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much life insurance coverage insurers will issue on one life.
7. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the life insurance policy or certificate of a group policy, to be forfeited by the owner. You should seek assistance from a professional financial advisor.
8. The insured may be contacted by the life settlement provider or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. The contacts 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.
9. You, the owner, have the right to rescind (cancel) a life settlement contract from the time of execution of the contract until fifteen days after you receive the life settlement proceeds.
10. The life settlement provider or life settlement broker is required to provide you, the owner, during the solicitation process with a consumer information booklet in a form prescribed by the New York Superintendent of Insurance, or other similar material, as may be approved by the Superintendent.

Policy Owner Initials _____

Policy Owner Initials _____

REQUIRED DISCLOSURES TO POLICY OWNER, Page 2.

11. You, the policy owner, will be provided with the following information:

- the “gross offer or bid” that the life settlement provider shall pay pursuant to the life settlement contract;
- the net amount to be paid to the owner pursuant to the life settlement contract;
- the name of each life settlement broker, life settlement intermediary, insurance producer or insurance consultant that will be compensated by the life settlement provider, or any affiliate, parent corporation, or subsidiary of the life settlement provider pursuant to the life settlement contract; and
- the amount of compensation that the life settlement provider, or any affiliate, parent corporation or subsidiary of the life settlement provider, shall provide to a life settlement broker, life settlement intermediary, insurance producer or insurance consultant, or any affiliate, parent corporation or subsidiary of such broker, intermediary, producer, or consultant pursuant to the life settlement contract.

“Gross offer or bid” means the total amount or value offered by the life settlement provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

12. The escrow agent or trustee must transfer the net proceeds under the life settlement contract to you, the owner, within three business days after the life settlement provider has received the insurer or group administrator’s acknowledgment that ownership of the life insurance policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.
13. The life settlement provider must provide you, the owner, with the name, business address, telephone number and e-mail address of the independent third-party escrow agent or trustee. You have the right to inspect or receive copies of the relevant escrow or trust agreements or documents.
14. The life settlement provider must provide you, the owner, with the date by which the funds will be available to you and the transmitter of the funds.
15. The life settlement provider must tell you, the owner, about any affiliations or contractual arrangements between it and the issuer of the life insurance policy to be settled.
16. The life settlement provider must tell you, the owner, about any affiliations or contractual arrangements with any other life settlement provider, life settlement broker, life settlement intermediary or party financing the transaction.
17. The life settlement provider must provide you, the owner, with the name, business address, telephone number and e-mail address of the life settlement provider.

(Signature Page Immediately Follows)

REQUIRED DISCLOSURES TO POLICY OWNER, Page 3.

LIFE INSURANCE POLICY OWNER’S ACKNOWLEDGMENT: I have read and received a copy of the disclosure form entitled “Required Disclosures to Policy Owner”, Further, I have read and received the consumer information booklet entitled “Life Settlements – What You Should Know Before Selling Your Life Insurance Policy” or a similar booklet to keep for my records.

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

LIFE INSURANCE 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. Two (2) witnesses are required if there is more than one (1) policy owner.

LIFE SETTLEMENT BROKER

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Policy Owner Initials _____

Policy Owner Initials _____



REQUIRED DISCLOSURES TO INSURED

IMPORTANT - READ THIS DISCLOSURE DOCUMENT BEFORE SIGNING IT.

You should carefully read the following information and seek financial, insurance or other advice where appropriate.

1. You, the insured, may be contacted by the life settlement provider or its authorized representative for the purpose of determining your health status or to verify your address. You may not be contacted more often than once every three months if you have a life expectancy of more than one year, and no more than once per month if you have a life expectancy of one year or less.
2. A change of ownership of the policy that is the subject of this life settlement contract could in the future limit your ability to purchase future insurance on your life because there is a limit to how much coverage insurers will issue on one life.
3. All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about you, the insured, including your identity or the identity of your family members, your spouse or significant other may be disclosed as necessary to effect the life settlement contract between the owner and 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.
4. ***No medical, financial or other personal information may be disclosed without your written consent.***

ACKNOWLEDGMENT OF THIS DOCUMENT DOES NOT CONSTITUTE CONSENT TO DISCLOSURE OF YOUR MEDICAL, FINANCIAL OR OTHER PERSONAL INFORMATION.

INSURED'S ACKNOWLEDGMENT: I have read and received a copy of the Required Disclosures to Insured and acknowledge with my signature below.

INSURED

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____



SUBMISSION CONSENT DISCLOSURE

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

The undersigned is the owner of, or named insured under, one or more life insurance policies identified below. In order to effect a life settlement contract between the owner and a life settlement provider, or to effectuate the sale or transfer of a life settlement contract or a settled policy, or interest therein, the undersigned each hereby consent to the release of information to the authorized recipients specified herein.

Information Authorized to be Released: Any information (1) concerning or related to the identity of the owner of, or the named insured under, the life insurance policies identified below, (2) that there is a reasonable basis to believe could be used to identify the insured or owner, and (3) concerning or related to the owner's or insured's financial or medical information may be released to the authorized recipients (as defined below). Such information may include (but is not limited to): the name, address, telephone numbers, social security number, tax records, medical records, credit information and other non-public personal information of or related to the insured or the owner, or representative thereof; and the related insurance policy number(s).

Authorized Recipients of Information: Information authorized to be released hereunder may be released to (1) any life settlement broker, (2) any life settlement provider (a "life settlement provider"), (3) any person who may seek to purchase from such life settlement provider any life insurance policy insuring the below identified insured's life or other insurance product owned by the below identified owner, (4) any financing entity of a life settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers, (5) any service provider, including, but not limited to, any life expectancy underwriter, escrow agent or post-purchase policy servicer, (6) any life insurance or annuity company that has issued a life insurance policy insuring the below identified insured's life, and (7) any of the respective affiliates, directors, officers, employees, agents, representatives, independent contractors, accountants, actuaries, attorneys and other representatives and advisors, and successors and assigns of any of the persons or entities covered in the immediately foregoing clauses (1) through (6), inclusive (each, an "authorized recipient"). Each authorized recipient in receipt of information authorized to be released by this authorization may share any such information with any other authorized recipient as if such other authorized recipient had received such information directly from the undersigned.

The undersigned each certify that this authorization has been made freely, voluntarily and without coercion and that the information shown below is accurate and complete to the best of the undersigned's knowledge. The undersigned understands that any revocation of this authorization will not apply to information that has already been released in response to this authorization. Redislosure of the undersigned's information by those receiving the above authorized information may be accomplished without the undersigned's further written authorization and may no longer be protected. The undersigned releases any authorized recipient from any and all liability for actual or alleged damages to the undersigned as a result of good faith compliance with this authorization.

SUBMISSION CONSENT DISCLOSURE, Page 2.

This authorization is valid for the duration of the life insurance policy(-ies) specified, provided that this authorization shall be of no force or further effect if a life settlement contract is not affected. The undersigned each acknowledge receipt of a copy of this authorization.

A copy of this authorization may be accepted as an original. This authorization may be sent via facsimile.

POLICY OWNER AND INSURED'S ACKNOWLEDGMENT: I have read and received a copy of the Submission Consent Disclosure and acknowledge with my signature below.

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED (if other than the policy owner)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____

LIFE INSURANCE POLICY OWNER

Signature: _____

Printed Name: _____

Date: _____

INSURED (if other than the policy owner)

Signature: _____

Printed Name: _____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____



BROKER AUTHORIZATION & SERVICES AGREEMENT

As one of the major firms in the settlement industry brokering life policies, Life Insurance Settlements, Inc. (LIS). 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 life settlement broker incurs the necessary, required and related costs to facilitate your life 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 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 LIS 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 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 John R. Haynie and the authorized representative LIS 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 LIS 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 John R. Haynie and the authorized representative LIS 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 Policy owner and the Insured, and owes duties to the Policy owner 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 use its best efforts, on behalf of the policy owner, to obtain the most favorable terms and conditions for the policy owner in respect of the sale of the policy, including, without limitation, the best price for the policy. LIS 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 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 LIS has a duty to find the most competitive offer available for my/our life insurance policy(ies). Therefore, I/we hereby grant to LIS 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

Signature: _____

Printed Name: _____

Date: _____

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: _____

LIFE SETTLEMENT BROKER

Signature: _____

Printed Name: _____

Date: _____