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: _____

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: _____

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: _____

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Complete for 2nd Insured, if applicable.

Medical History: _____

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

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

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.

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 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

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

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: _____

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. Redisclosure 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: _____

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: _____

WITNESS

Signature: _____

Printed Name:_____

Date: _____

WITNESS

Signature: _____

Printed Name: _____

Date: _____