LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market
1180 SW 36th Avenue, Suite 201
Pompano Beach, FL 33069
Telephone: 866-326-5433

VIATICAL SETTLEMENT INQUIRY FORM

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 Viator? ☐ Yes ☐ No (A viator is the owner of a life insurance policy who seeks to enter into a viatical settlement contract.)

Name of Viator: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

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

Current 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 medical or physician information, please provide a supplementary page.

VIATICAL SETTLEMENT INQUIRY FORM, Page 2

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., Viatical 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 the 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.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 and medical exam.
B. Copy of Insured and Viator 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 INQUIRY FORM, Page 3

The undersigned acknowledges they have read and fully understand this viatical settlement application. The Florida Office of Insurance Regulation want you to have the facts and know your rights before you sell your life insurance policy. Always check your state laws.

VIATOR

Signature: _____

Printed Name:_____

Date: _____

VIATOR

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: _____

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

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 my health and medical data, information and records, whether 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.

_____ Viator Initials _____ Viator Initials

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.

_____ Viator Initials _____ Viator Initials

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 forms 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: _____

_____ Viator Initials

_____ Viator Initials

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market

DISCLOSURE TO VIATICAL SETTLEMENT APPLICANT

With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures by the date of application for a viatical settlement contract.

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

The owner of the life insurance policy, the viator, should be aware of the following:

1. That there are possible alternatives to viatical settlement contracts for persons who have a catastrophic or life-threatening illness including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.

2. That proceeds of the viatical settlement could be taxable, and assistance should be sought from a personal tax advisor.

3. That viatical settlement proceeds could be subject to the claims of creditors.

4. That receipt of viatical settlement proceeds could adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements and advice should be obtained from the appropriate agencies.

5. That all viatical settlement contracts entered into in Florida must contain an unconditional rescission provision which allows the viator to rescind the contract within 15 days after the viator receives the viatical settlement proceeds, conditioned on the return of such proceeds.

6. The viatical settlement provider company, not the viator, 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 policy could be: 8% x $100,000 (face value) = $8,000.00.

7. The viator has the right to obtain the name, business address, and telephone number of the independent third-party escrow agent and the viator may inspect or receive copies of the relevant escrow agreement.

8. That the viator has the right to know, upon request, the identity of any person who will receive or has received a commission or other form of compensation from the viatical settlement provider with respect to their viatical settlement and the amount and terms of such compensation.

Signature page to follow

_____ Viator Initials _____ Viator Initials

DISCLOSURE TO VIATICAL SETTLEMENT APPLICANT, Page 2

VIATOR'S ACKNOWLEDGMENT: I have read and fully understand this disclosure form. I have received a copy of this disclosure to keep for my records.

LIFE INSURANCE POLICY OWNER/VIATOR

Signature: _____

Printed Name:_____

Date: _____

LIFE INSURANCE POLICY OWNER/VIATOR

Signature: _____

Printed Name: _____

Date: _____

VIATICAL SETTLEMENT BROKER

Signature: _____

Printed Name: _____

Date: _____

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

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market

THIRD PARTY 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.

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
Oleg Eydelman	Senior Analyst
Mark Mrky	Senior Analyst
Gage Gaynor	Broker
Gibson Nutt	Broker
Jack Carlton	Broker
Nicole Lee	Senior Case Manager, Contract Services
AnnMarie Partis	Senior Case Manager
David Cooper	Senior Case Manager
Logan Gaynor	Case Manager

Signature: _____ Signature: _____

Printed Name:_____ Printed Name: _____

Date: _____ Date: _____

_____ _____
Viator Initials Viator Initials