LIFE 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? ☐ No ☐ Yes

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: _______________________

Specialist: __________________________________ Telephone number: _______________________

Complete for Second Insured, if applicable.

Medical History of Insured: ____

Primary Physician: ___________________________ Telephone number: _______________________

Specialist: __________________________________ Telephone number: _______________________

Specialist: __________________________________ Telephone number: _______________________

For additional medical or physician information, please provide a supplementary page.

LIFE 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 – POLICY OWNER

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

Complete if Policy Owner is an individual other than the Insured.

Name of Policy Owner: ____

Relationship to Insured: ____

Date of Birth: ____________________________ SSN: ___________________________________

Address: ____

City: ___________________________ State: _________________ Zip Code: _____________________

Phone Number: ____________________________ Email Address: ______________________________

Drivers License Number: ____________________________________ State of Issue: ________________

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? ☐ Yes ☐ No

Has the policy owner ever declared bankruptcy? ☐ Yes ☐ No

Complete if Policy Owner is Trust, Corporation, Partnership, or Other Entity.

Name of Policy Owner: ____

Name of Authorized Representative and Title: ____

Tax ID Number: _________________________________ State of Formation: _______________________

Address: ____

City: _______________________________ State: _______________ Zip Code: _____________________

Phone Number: ____________________________ Email Address: _________________________________

Is the policy owner a defendant in any suits or legal actions? ☐ Yes ☐ No

Has the policy owner ever declared bankruptcy? ☐ Yes ☐ No

LIFE SETTLEMENT APPLICATION, Page 3

Please complete the following questions.

1. Has the Policy Owner changed since the policy was issued? ☐ Yes ☐ No

   If yes, please list name of initial 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 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, 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 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.

   ____

   If yes, name of Lender: ____

   Principal loan amount: ____

   Loan Maturity balance (*payoff amount*):____

   Loan Maturity date: ____

LIFE SETTLEMENT APPLICATION, Page 4

8. 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 to the trust.

   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: ______________________________________

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 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, 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. 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)

The undersigned acknowledges they have read and fully understand this Life Settlement application.

LIFE INSURANCE POLICY OWNER

Signature: ____________________________________

Printed Name: __________________________________

Date: ____

LIFE INSURANCE POLICY OWNER

Signature: ____________________________________

Printed Name: __________________________________

Date: ____

INSURED

Signature: ____________________________________

Printed Name: __________________________________

Date: ____

INSURED

Signature: ____________________________________

Printed Name: __________________________________

Date: ____

WITNESS

Signature: ____________________________________

Printed Name: __________________________________

Date: ____

WITNESS

Signature: ____________________________________

Printed Name: __________________________________

Date: ____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PERMISSION TO SHARE INFORMATION

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 Number: ____________________________ 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 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.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, Page 2

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.

5. Expiration: I understand this authorization will remain in effect for a maximum of one (1) year from the date of signature or until the specific date of ________________________.

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 a 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.

PATIENT OR INDIVIDUAL

Signature: ______________________________

Printed Name: __________________________

Date: __________________________________

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.***)

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.

LIFE INSURANCE POLICY OWNER

Signature: ______________________________

Printed Name: ______________________________

Tax ID/SSN: ______________________________

Date: ______________________________

LIFE INSURANCE POLICY OWNER

Signature: ______________________________

Printed Name: ______________________________

Tax ID/SSN: ______________________________

Date: ______________________________

LIFE SETTLEMENT BROKER DISCLOSURES TO OWNER

Arizona law allows you to sell your life insurance policy to a third party for an amount that is less than the full death benefit. The buyer becomes the new owner and the beneficiary of the life insurance policy, pays all future premiums and collects the entire death benefit when you die. This is called a life settlement contract.

Arizona Revised Statutes ("ARS") § 20-3204, subsections A and B, require that a life settlement provider or life settlement broker provide you with the following information in writing before you apply for or enter into a life settlement contract:

IMPORTANT: READ THIS DISCLOSURE DOCUMENT BEFORE SIGNING A LIFE SETTLEMENT CONTRACT.

Before you submit an application for a life settlement, you should know:

1. There are possible alternatives to life settlements, including accelerated benefits options that your life insurer may offer or policy loans.

2. Some or all of the proceeds of a life settlement may be taxable. You should seek assistance from a professional tax adviser.

3. The proceeds from a life settlement could be subject to the claims of creditors.

4. Receiving proceeds from a life settlement contract may adversely affect your eligibility for public assistance or other government benefits or entitlements. You should obtain advice from the appropriate agencies.

5. Entering into a life settlement contract may cause you to forfeit other rights or benefits including conversion rights and waiver of premium benefits that you may have under the policy or certificate of a group policy. You should seek assistance from a professional financial adviser.

6. You can rescind the life settlement contract within **fifteen (15) days** after the date that all parties execute the life settlement contract and you have received all required disclosures (the "rescission period"). To rescind the life settlement contract, you must notify the provider in writing, and you must repay all proceeds and any premiums, loans and loan interest paid on account of the provider during the rescission period. If the insured dies during the rescission period, the life settlement contract shall be deemed rescinded once you or your estate repay all proceeds and any premiums, loans and loan interest to the provider.

7. Before the provider can pay you the proceeds from the life settlement contract, the provider needs to be notified by the life insurer or group administrator that the ownership of the policy or the interest in the certificate of insurance has been transferred, and that the beneficiary has been designated according to the terms of the life settlement contract. The provider is required to pay you the proceeds from the life settlement contract within three business days after the provider has received the insurer or group administrator's notification.

 Policy Owner's Initials ___________

LIFE SETTLEMENT BROKER DISCLOSURES TO OWNER, Page 2.

8. The provider should tell you the date by which the monies will be available to you and the transmitter of the monies.

9. The provider or the broker or its authorized representative may periodically contact the insured to determine the insured's health status or to verify the insured's address. **This contact is limited to once every three months if the insured has a life expectancy of more than one year, and is limited to once per month if the insured has a life expectancy of one year or less.**

10. Document Forms LIS.AZ – LSBCOD(a) through (c) will be provided to the policy owner before all parties sign any life settlement contract. These forms provide information about the broker, and notifies you of any affiliation or contractual relations between the provider and the broker, and any affiliation between the provider and the issuer of the policy to be settled

11. Any fee paid by a provider, party, individual or owner to a broker in exchange for services provider to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained and not the face value of the policy. This section does not prohibit a broker from reducing the broker's fee below this percentage if the broker so chooses.

12. A broker represents you exclusively and not the insurer or the provider or any other person. The broker owes a fiduciary duty to you, including a duty to act according to your instructions and in your best interest.

    All medical, financial or personal information solicited or obtained by a provider or 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 life settlement contract between you and the 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 monies for the purchase. You may be asked to renew your permission to share information every two years. Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a class 1 misdemeanor and may be subject to fines and confinement in jail.

Signature required by ARS § 20-3204(A). By signing this form, you acknowledge that you read and understand the information contained on this disclosure document. If you need legal advice, you should consult an attorney.

LIFE INSURANCE POLICY OWNER	**LIFE INSURANCE POLICY OWNER**
Signature: ________________________________	**Signature:** ________________________________
Printed Name: ____________________________	**Printed Name:** ____________________________
Date: ____________________________________	**Date:** ____________________________________

LIFE SETTLEMENT BROKER

Signature: ________________________________

Printed Name: ____________________________

Date: ____________________________________

Policy Owner's 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. 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 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 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.

In all respects in connection with the transaction, the Broker, Life Insurance Settlements, Inc. 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. The Broker, Life Insurance Settlements, Inc. will 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. 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 life settlement provider for the policy(ies) and is not responsible for any breach committed by a life settlement provider, if such life settlement provider is identified.

I/We understand that 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 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

Signature: ____________________________________

Printed Name: _________________________________

Date: ____

LIFE INSURANCE POLICY OWNER

Signature: ____________________________________

Printed Name: _________________________________

Date: ____

INSURED

Signature: ____________________________________

Printed Name: _________________________________

Date: ____

INSURED

Signature: ____________________________________

Printed Name: _________________________________

Date: ____

LIFE SETTLEMENT BROKER

Signature: ____________________________________

Printed Name: _________________________________

Date: ____