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: ______________________

Complete for Second 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.

__________ Owner Initials __________ Owner Initials

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

If yes, please answer the following and move to page 3. If no, please proceed to section E or F accordingly.

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

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

E. 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: __________________

Telephone Number: _______________________ Email Address:_____________________________

Driver's 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

F. 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: __________________

Telephone 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

__________ Owner Initials __________ Owner Initials

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.

   ____

   Name of Lender: ______________________________

   Principal loan amount: ______________________________

   Loan Maturity balance (*payoff amount*):________________ Loan Maturity date: ______________________

Owner Initials Owner Initials

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., and all Life Settlement Providers licensed in Idaho where the life settlement case may be submitted for review.

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

Insurance fraud includes, but is not limited to: Any person who, with the intent to defraud or deceive an insurer for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, producer, practitioner or other person, any statement as part of, or in support of, a claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim; or any person who, with intent to defraud or deceive, presents or causes to be presented to or by an insurer, a producer, practitioner or other person, a false or altered statement material to an insurance transaction. Any violator of this section Idaho Code 41-293 is guilty of a felony.

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)

__________ Owner Initials   __________ Owner Initials

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: ____

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

__________ Owner Initials __________ Owner Initials

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH 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: ________________________________ 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.

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: 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. The information disclosed may only be true and correct to my knowledge and belief.

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.

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: ______________________________

DISCLOSURE TO LIFE SETTLEMENT APPLICANT

(To be provided no later than at time of application for any life settlement agreement)
(With acknowledgement of life settlement broker)

IMPORTANT – READ THIS DISCLOSURE FORM AND THE ENCLOSED LIFE SETTLEMENT INFORMATION BROCHURE BEFORE SIGNING ANY LIFE SETTLEMENT AGREEMENT. You should carefully read all of the following points and seek financial, insurance, tax and other advice where appropriate.

1. Possible alternatives to life settlement contracts include any accelerated death benefits or policy loans offered under your life insurance policy.

2. A life settlement broker exclusively represents you, the owner, and not the insurer or the life settlement provider, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

3. Some or all of the proceeds of the life settlement may be taxable under federal and state law, and assistance should be sought from a professional tax advisor.

4. Proceeds of the life settlement could be subject to the claims of your creditors.

5. Receipt of the proceeds of a life settlement may adversely affect your eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

6. You have the right to rescind (cancel) a life settlement contract within twenty (20) days of the date it is signed by all parties. If you want to rescind the contract, you must provide notice to the life settlement provider and repay all proceeds and any premiums, loans and loan interest paid on account of the life settlement contract within the twenty (20) day rescission period. If the insured dies during the twenty (20) day rescission period, the life settlement contract will be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all life settlement proceeds and any premiums, loans and loan interest.

7. Funds will be sent to you within three (3) business days after the life settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

8. Entering into a life settlement contract may cause you to forfeit other rights or benefits including conversion rights and waiver of premium benefits that may exist under the policy or certificate. Assistance should be sought from a financial adviser.

_______ Owner Initials _______ Owner Initials

9. You will be provided a brochure approved for use by the Department of Insurance that describes the process of life settlements. You should review this brochure carefully.

10. All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement 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 between the owner and the life settlement 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 (2) years.

11. Following execution of a life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in sections 41-1950 through 41-1965, Idaho Code. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less. All such contacts shall be made only by a life settlement provider licensed in the state of Idaho.

12. If you have any questions, you may call the Idaho Department of Insurance at 800-721-3272 or 208-334-4250.

13. The life settlement provider, not the policy owner, 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 $100,000.00 policy could be: 8% x $100,000.00 (face value) = $8,000.00. The amount and method of calculation will be disclosed to the policy owner prior to execution of a life settlement contract.

LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT: I have read and fully understand this disclosure form. I have received copies of this disclosure form and the life settlement information brochure to keep for my records.

LIFE INSURANCE POLICY OWNER

Signature: ___________________________________

Printed Name:________________________________

Date: _______________________________________

LIFE INSURANCE POLICY OWNER

Signature: ___________________________________

Printed Name: ________________________________

Date: _______________________________________

LIFE SETTLEMENT BROKER

Signature: ___________________________________

Printed Name:________________________________

Date: _______________________________________

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

__________ Owner Initials __________ Owner 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.

__________ Owner Initials __________ Owner Initials

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 (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: ________________________________

__________ Owner Initials __________ Owner Initials