



## **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? ☐ Yes ☐ No

**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.*

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

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

**E. Complete if Policy Owner is an Individual**

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

## **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.

\_\_\_\_\_  
Name of Lender: \_\_\_\_\_

Principal loan amount: \_\_\_\_\_

Loan Maturity balance (*payoff amount*): \_\_\_\_\_ Loan Maturity date: \_\_\_\_\_

**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 Kentucky 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**

**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.

**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)

***Signature page to follow.***

**LIFE SETTLEMENT APPLICATION, Page 5**

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

This application was signed and witnessed in the County of \_\_\_\_\_, State of \_\_\_\_\_.

**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.*

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION



<b>A. Patient's Name (please print):</b>	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.

<b>Released From:</b>  Name: _____ Address: _____  Telephone: _____ Fax: _____	<b>Released To:</b>  Life Insurance Settlements, Inc. 1180 SW 36 <sup>th</sup> Avenue, Suite 201 Pompano Beach, FL 33069 Telephone: 1-866-326-5433
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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.

## **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.



## **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**

**IMPORTANT – READ THIS DISCLOSURE FORM AND THE ENCLOSED LIFE SETTLEMENT INFORMATION BROCHURE BEFORE THE LIFE SETTLEMENT CONTRACT IS SIGNED BY ALL PARTIES. You should carefully read the following points and seek financial, insurance, tax and other advice where appropriate.**

1. Always check to see if there are possible alternatives to selling your policy. For example, check your insurance policy to see if you have an accelerated death benefit rider.
2. The life settlement proceeds may be subject to the claims of creditors.
3. Some or all of the proceeds of the life settlement may be taxable, and that assistance should be sought from a professional tax advisor.
4. Receipt of life settlement proceeds may affect your eligibility for Medicaid or other government benefits.
5. Your life insurance policy may have additional benefits such as coverage for long-term care, and may even be additional family members insured. Review your policy and be sure you are aware of all the benefits included before you decide to sell the policy and risk the loss of the additional benefits.
6. You have the option to cancel the life settlement contract within 30 days after the contract is signed by all parties, or within 15 days after you receive the proceeds.
7. You will receive the proceeds from the life settlement within 3 days after the change of ownership and beneficiary has been completed.
8. The insured may be contacted once every 3 months to verify the insured's health status and address.
9. The insured's private information may be provided to someone who buys the policy or provides the funds for the purchase.
10. Selling the life insurance policy of an insured may limit the amount of life insurance the insured will be able to purchase in the future.
11. The life settlement provider company, not the policy owner, may compensate Life Insurance Settlements, Inc. (LIS) based on a formula that is a percentage of the offer obtained, not the face value of the policy. Life Insurance Settlements will disclose to the owner anything of value or given to LIS which relates to the life settlement contract.

***Signature page to follow.***

**DISCLOSURE TO LIFE SETTLEMENT APPLICANT, Page 2**

**LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT:** This disclosure is being delivered as a requirement of the Kentucky Department of Insurance. I have read and fully understand this disclosure form and received a copy of the Kentucky Consumer Guide to Understanding Life Settlements.

**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 SETTLEMENT BROKER**

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.*



## **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.

## **BROKER AUTHORIZATION & SERVICES AGREEMENT, Page 2**

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: \_\_\_\_\_

\_\_\_\_\_