



## **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**

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, please include all parties, including but not limited to: grantor(s), trustee(s), and beneficiary(ies).

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 Entities.
- 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.

## **LIFE SETTLEMENT APPLICATION, Page 5**

### **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, inter vivos 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. Prevailing applicable law may be found in Massachusetts General Laws Chapter 175, §212-§223F.**

#### **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 36<sup>th</sup> Avenue, Suite 201  
Pompano Beach, FL 33069

<b>A. Patient's Name</b> ( <i>please print</i> ):	Date of Birth: ____/____/____ <small>Month Day Year</small>	Medical Record Number (if known):
Address:	Telephone Number	Social Security Number ( <i>last 4 digits</i> ):

**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 ("HIP") 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: This authorization to disclose personal health information shall remain valid for twelve (12) months following the date of signature. If authorization shall remain valid for a specific length of time that is less than twelve (12), 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 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. A copy of this authorization is as valid as the original.

### **PATIENT OR INDIVIDUAL**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **PERSON AUTHORIZED TO SIGN ON BEHALF OF PATIENT OR INDIVIDUAL**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

***(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**

<b>Policy Owner:</b>	_____
<b>Insured:</b>	_____
<b>Policy Number:</b>	_____
<b>Insurance Carrier:</b>	_____

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.

### **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**

**IMPORTANT** – READ THIS DISCLOSURE FORM AND THE ENCLOSED LIFE SETTLEMENT INFORMATION BROCHURE BEFORE SIGNING ANY LIFE SETTLEMENT AGREEMENT. Not later than the date of application for a life settlement contract, a life settlement provider shall provide to the owner the following information:

1. There are possible alternatives to life settlement contracts exist including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy.
2. Some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax advisor.
3. The proceeds from a life settlement contract may be subject to the claims of creditors.
4. Receipt of proceeds from a life settlement contract may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies.
5. The owner has a right to terminate a life settlement contract not more than 15 days after the date it is executed by all parties.
6. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans and loan interest paid on account of the life settlement provider within the rescission period. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the life settlement provider.
7. Proceeds will be sent to the owner within 3 business days after the life settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.
8. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy, to be forfeited by the owner and that assistance should be sought from a professional financial advisor.
9. The amount and method of calculating the compensation paid, or to be paid, to the life settlement broker or any other person acting for the owner in connection with the transaction will be disclosed to the policy owner. The life settlement provider company, not the owner, may compensate LIS based on a formula that is a percentage of the offer obtained, not the face value of the policy.
10. The date by which the funds will be available to the owner and the transmitter of the funds.

## **LIFE SETTLEMENT BROKER DISCLOSURES TO OWNER, Page 2.**

11. 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 the insured's family members, a spouse or a significant other, may be disclosed as necessary to effect the life settlement contract 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 2 years.
12. The insured may be contacted by either the life settlement provider or life settlement broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address; provided, however, that this contact shall be limited to once every 3 months if the insured has a life expectancy of more than 1 year and not more than once per month if the insured has a life expectancy of 1 year or less.
13. You will be notified of any affiliation or contractual relations between the provider and the broker, and any affiliation between the provider and the issuer of the insurance policy to be settled.
14. The life settlement broker represents exclusively the owner and not the insurer, the life settlement provider or any other person and that the broker 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.
15. The name, business address and telephone number of the independent third party escrow agent and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents.
16. A change of ownership may, in the future, limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on 1 life.

**By signing below, the policy owner affirms they were provided this disclosure document by Life Insurance Settlements, Inc., along with an NAIC brochure entitled "Selling Your Life Insurance Policy - Understanding Viatical Settlements". The policy owner affirms they have read the above disclosures and referenced brochure. Prevailing applicable law may be found in Massachusetts General Laws Chapter 175, §212-§223F. Please note, any violation of sections 213 to 223E, inclusive, shall be an unfair trade practice. 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.**

### **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.*



## **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 from Florida licensed companies.
- Submission to multiple licensed 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) \_\_\_\_\_:

Life insurance policy number \_\_\_\_\_ Issued by \_\_\_\_\_

Life insurance 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 stated 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 Provider 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

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

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: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_