

SETTLEMENT APPLICATION

A. PERSONAL INFORMATION (PLEASE PRINT OR TYPE)

Insured's Name	Date of Birth	S	ocial Security Number	
2 nd Insured's Name	Date of Birth	Social Security Number		
Address		P	hone Number	
City	State Zip Co		ip Code	
B. LIFE INSURANCE INFORM	MATION			
Insurance Company	Policy Number		Face Amount	
Date of Issue	Policy Type (WL,	UL, SUL, Term, et	tc) Current Premium	
Policy Owner	State of Residence	·	Beneficiary(s)	
Is the policy owner a defendant in any so	he policy owner a defendant in any suits or legal actions? Yes		No	
Has the policy owner ever declared bank	kruptcy?	Yes	No	
Marital Status: Single/Never Married	Married	Widowed	Divorced	
C. MEDICAL INFORMATION	ſ			
Insured Medical History				
2 nd Insured Medical History				
Primary Physician	Telephone Number			
Specialist		Telephone Number		

For additional policy and/or physician information, please provide a supplementary page.

For Agent Use: If available, please include the following: 1) Current in force Illustration to maturity. 2) Current APS (if not within the last 90 days, please provide physician information in Section C).



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/Viatical Settlement Providers and Financing Sources.
- B. The undersigned will immediately notify Life Insurance Settlements, Inc. of any material change in any information contained herein, occurring prior to 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/VIATICAL 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, viatical settlements, intervivos settlements, or other similar terms.

An applicant must determine the relative benefit of any such living benefit settlement after review of the legal and financial implications of such a settlement with the applicant's own attorney, accountant, or other appropriate advisors, only then, should a decision be made to effect such a sale or settlement.

Applicant has a clear & 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. Life Insurance policy to be sold, including the application for insurance
- B. Your Driver's License
- C. Last premium statement from your Life Insurance company (if available)
- D. Social Security Card

Applicant's Full Name (Type or Print)	Applicant Signature	Date
Witness' Full Name (Type or Print)	Witness Signature	Date



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I, the undersigned, 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 photo static or facsimile copy or other reproduction of this authorization.
- 2. <u>Classes of Persons Authorized to Receive My Protected Health Information</u>: 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 and Purpose of 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 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.
- 4.Expiration: This authorization shall remain valid until, and shall expire, one year after the date of my death.
- 5.<u>Right to Revoke Authorization</u>: 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.
- 6.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 the HIPAA Privacy Regulations may no longer protect my PHI that is disclosed to such Authorized Recipient.

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.

Signature of Individual	Date	Signature of Personal Representative of Individual	Date
Print or Type Name of Individual	Date	Description of Personal Representative's Authority:	
31		(Power of Attorney, Guardian ad Litem or similar statu	us)



Life Insurance Information Release Form

Life insurance policy number	issued by
(Insurance Company), is owned by	, and insured the life of
concerning the above policy. I authorize LIS to share this information v	e Settlements, Inc. (LIS) or its designee, any or all information with life settlement providers, brokerage general agents, and other haring of information is to obtain quotes for life settlements, and
Policy Owner Signature	Date
Type or Print Name	Social Security Number



DISCLOSURE

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

- 1. That there are possible alternatives to viatical settlements, including any accelerated death benefits or loans offered under the viator's life insurance policy.
- 2. That some or all of the proceeds of the viatical settlement may be taxable under the federal income tax or a state franchise or income tax laws, and assistance should be sought from a professional tax adviser.
- 3. That proceeds of the viatical settlement may be subject to the claims of creditors.
- 4. That receipt of proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate governmental agencies.
- 5. That the viator has a right to rescind the viatical settlement contract within fifteen (15) calendar days after receipt of the viatical settlement proceeds by the viator, as provided by Nebraska law, in subsection (3) of section 44-1109. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded. If a viatical settlement contract is rescinded, all viatical settlement proceeds and any premiums paid by the viatical settlement provider or purchaser shall be repaid to the viatical settlement provider or purchaser within sixty days of such rescission.
- 6. That entering into a viatical settlement may cause other rights or benefits, including conversion rights and waiver of premium benefits, which may exist under the policy or certificate to be forfeited by the viator, and assistance should be sought from a financial adviser.
- 7. That the insured may be contacted by either the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every six months if the insured has a life expectancy of more than one year, and no more than once every three months if the insured has a life expectancy of one year or less. For purposes of this subdivision, authorized representative does not include a viatical settlement purchaser.
- 8. That all medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including identity or the identity of family members, a spouse or a significant other, may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. Failure to consent may affect your ability to viaticate your policy. The information may be furnished to someone who buys the policy or provides money for the purchase. You may be asked to renew your permission to share information every two years.



I have received a brochure, which describes the process of viatical settlements in the form prescribed by the National Association of Insurance Commissioners and provided as part of the viatical settlement disclosure.

Signature of Insured	Date	Signature of Policy Owner (Viator)	Date
Printed Name	Date	Printed Name	Date
Signature of Witness	Date	Signature of Witness	Date
Printed Name	Date	Printed Name	Date
LIS Representative	Date	Printed Name	Date