LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market

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.

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: _____

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

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

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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., Life Settlement Providers and Financing Sources.

B. The undersigned will immediately notify Life Insurance Settlements, Inc. of any material change in any information contained herein, occurring prior to conclusion of the proposed sale, including but not limited to: cancellation and release of insurance policies, assignment of ownership of policies, change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies.

The proposed sale, cancellation and release of insurance policies, assignment of ownership of policies, or change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies will be solely for the benefit and account of the undersigned, and not for the account or benefit of any other person.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE SETTLEMENT CONTRACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO APPLICANTS

Neither Life Insurance Settlements, Inc. nor it's officers, directors, or principals provide legal, accounting, or financial advice to prospective applicants regarding the advisability or relative merits of selling or conveying their legal rights in existing life insurance policies in exchange for cash payments referred to as living benefits, life settlements, intervivos settlements, or other similar terms.

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

Applicant has a clear and complete understanding of the current or future benefits of the life insurance policy being offered for sale or settlement. Applicant acknowledges that he/she has freely and voluntarily provided the information requested in this application.

PLEASE SEND WITH THE COMPLETE APPLICATION FORM, PHOTOCOPIES OF THE FOLLOWING:

A. Copy of Life Insurance Policy to be sold, including the application for insurance
B. Copy of Insured and Policy Owner Picture ID
C. Copy of Social Security Card
D. Last Premium Statement from your life insurance company (if available)

Signature page to follow.

_____ _____
Owner Initials Owner Initials

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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.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market
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.

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 SETTLEMENTS INC
Financial Options for the Secondary Market

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, viatical settlement broker, and viatical 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 forms 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: _____

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market

DISCLOSURE TO LIFE SETTLEMENT APPLICANT

(To be provided no later than at time of application for any life settlement contract)

IMPORTANT: READ THIS DISCLOSURE FORM BEFORE SIGNING ANY LIFE SETTLEMENT CONTRACT.

You should carefully read all the following points and seek financial, insurance, tax and other advice where appropriate.

1. There may be possible alternatives to life settlements which exist and include, but are not limited to, accelerated benefits options that may be offered by your life insurer.

2. Some or all of the proceeds of a life settlement may be taxable. Assistance should be sought from a professional tax adviser.

3. There may be an impact on the receipt of public assistance. The recipient should contact the State Department of Health Care Services and the State Department of Social Services under Section 11022 of the Welfare and Institutions Code for further information.

4. Proceeds from a life settlement could be subject to the claims of creditors;

5. 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. Assistance should be sought from a financial adviser.

6. Entering into a life settlement could limit the insured's ability to purchase life insurance in the future because there is a limit to how much coverage insurers will issue on one life.

7. The owner has a right to rescind a life settlement contract within thirty (30) days of the date it is executed by all parties and the owner has received all required disclosures, or fifteen (15) days from receipt by the owner of the proceeds of the life settlement, whichever is sooner. Rescission will only be effective if both notice of rescission is given and all proceeds and any premiums, loans, and loan interest paid on account of the provider are repaid within the rescission period. If the insured dies during the rescission period, the 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 provider.

8. Proceeds will be sent to the owner within three (3) business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy of the interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

Owner Initials _____ Owner Initials _____

9. All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and 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.

10. The insured may be contacted by either the provider or the broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is 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.

11. The broker represents the owner, exclusively, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act at any times according to the owners' instructions and in the best interest of the owner.

12. The name, business address, and telephone number of the life settlement broker are as follows:

    Life Insurance Settlements, Inc.
    1180 SW 36th Avenue, Suite 201
    Pompano Beach, FL 33069
    Telephone: 866-326-5433

13. The life settlement provider company, not the 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 policy could be: 8% x $100,000 (face value) = $8,000.00.

LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT: I have read and fully understand this disclosure form. I have received a copy of this disclosure 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: Steve Shorr Steve@SteveShorr.com 310.519.1335

Date: _____