# VIATICAL 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.***

## VIATICAL 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 – VIATOR/SELLER

**Is the Insured also the Viator/Seller?** ☐ Yes ☐ No

**Complete if Viator is an individual other than the Insured.**

Name of Viator: _____

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 Viator a defendant in any suits or legal actions? ☐ Yes ☐ No

Has the Viator ever declared bankruptcy? ☐ Yes ☐ No

**Complete if Viator is Trust, Corporation, Partnership, or Other Entity.**

Name of Viator: _____

Name of Authorized Representative and Title: _____

Tax ID Number: _____ State of Formation: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Is the Viator a defendant in any suits or legal actions? ☐ Yes ☐ No

Has the Viator ever declared bankruptcy? ☐ Yes ☐ No

**VIATICAL 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:_____

**VIATICAL SETTLEMENT APPLICATION, Page 4**

8. 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, include all beneficiaries to the trust.

   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., 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 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.

A viator 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 viator's own attorney, accountant, or other appropriate advisors, only then, should a decision be made to effect such a sale or settlement.

Viator has a clear and complete understanding of the current or future benefits of the life insurance policy being offered for sale or settlement. Viator 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 Viatical Settlement application.**

**VIATOR/SELLER**

**Signature:** _____

**Printed Name:** _____

**Date:** _____

**VIATOR/SELLER**

**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

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market SM
1500 West Cypress Creek Road, Suite 408
Fort Lauderdale, FL 33309

| **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.

| **From / Between** (Circle): | **To / Between** (Circle): |
|---|---|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| FAX Number: _____ | FAX Number: _____ |
| Telephone Number: _____ | Telephone Number: _____ |

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.

## 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: I understand this authorization will remain in effect for a maximum of one (1) year from the date of signature or until the specific date of _____.

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.

**PATIENT OR INDIVIDUAL**

Signature: _____

Printed Name: _____

Date: _____

**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*.)**

# LIFE INSURANCE INFORMATION RELEASE FORM

**Policy Owner:** _____

**Insured:** _____

**Policy Number:** _____

**Insurance Carrier:** _____

I hereby authorize my insurance company to furnish Life Insurance Settlements, Inc. (LIS) and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, with any information, verbal or written, including any illustrations, verification of coverage, forms, copies of 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 viatical settlement providers, viatical settlement brokers, and other parties, as required. The purpose of this sharing of information is to obtain quotes for viatical settlements.

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.

I agree and acknowledge this authorization shall remain valid for one (1) year after the date of signature.

**POLICY OWNER/VIATOR**

**Signature:** _____

**Printed Name:** _____

**SSN/Tax ID:** _____

**Date:** _____

**POLICY OWNER/VIATOR**

**Signature:** _____

**Printed Name:** _____

**SSN/Tax ID:** _____

**Date:** _____

LIFE INSURANCE SETTLEMENTS INC
Financial Options for the Secondary Market SM

# 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 settlement contracts for persons who have a catastrophic or life-threatening illness including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.

2. That proceeds of the viatical settlement could be taxable, and assistance should be sought from a personal tax advisor.

3. That viatical settlement proceeds could be subject to the claims of creditors.

4. That receipt of viatical settlement proceeds could adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements and advice should be obtained from the appropriate agencies.

5. That all viatical settlement contracts entered into in Florida must contain an unconditional rescission provision which allows the viator to rescind the contract within 15 days after the viator receives the viatical settlement proceeds, conditioned on the return of such proceeds.

6. The viatical settlement provider company, not the viator, 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.

7. The viator has the right to obtain the name, business address, and telephone number of the independent third-party escrow agent and the viator may inspect or receive copies of the relevant escrow agreement.

8. That the viator has the right to know, upon request, the identity of any person who will receive or has received a commission or other form of compensation from the viatical settlement provider with respect to their viatical settlement and the amount and terms of such compensation.

**VIATOR/POLICY OWNER**

**Signature:** _____

**Printed Name:** _____

**Date:** _____

**VIATOR/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:** _____

***This signature page may be duplicated if there are more than two (2) policy owners.***
***Two (2) witnesses are required if there is more than one (1) policy owner and/or more than one (1) insured.***

# VIATICAL SETTLEMENT 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 viatical settlement broker, Life Insurance Settlements, Inc. incurs the necessary, required and related costs to facilitate your viatical 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 authorized and /or registered viatical settlement providers.
- Best execution negotiation to maximize fair market value of viatical settlement.
- Closing services including contract review and assistance with contingency requirements of viatical 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 viatical settlement 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 _____

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 viatical settlement 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 viatical settlement broker, Life Insurance Settlements, Inc. will act exclusively on behalf of the Viator and the Insured, and owes duties to the Viator and the Insured, and has not acted on behalf of, and owes no duties to, the Viatical Settlement Provider or its successors or permitted assigns. The Viatical Settlement Broker, Life Insurance Settlements, Inc. will use its best efforts, on behalf of the Viator, to obtain the most favorable terms and conditions for the Viator 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 Viatical Settlement Provider for the policy(ies) and is not responsible for any breach committed by a Viatical Settlement Provider, if such Viatical Settlement Provider is identified.

## VIATICAL SETTLEMENT BROKER AUTHORIZATION & SERVICES AGREEMENT, Page 2

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.

**VIATOR/POLICY OWNER**

**Signature: _____**

**Printed Name: _____**

**Date: _____**

**VIATOR/POLICY OWNER**

**Signature: _____**

**Printed Name: _____**

**Date: _____**

**INSURED**

**Signature: _____**

**Printed Name: _____**

**Date: _____**

**INSURED**

**Signature: _____**

**Printed Name: _____**

**Date: _____**

**VIATICAL SETTLEMENT BROKER**

**Signature: _____**

**Printed Name: _____**

**Title: _____**

**Date: _____**