

SENIOR LIFE SETTLEMENT APPLICATION

Insured's Personal Information

Insured's Name: _____ Social Security #: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home # () _____ Work # () _____ Cell # () _____

Fax # () _____ Email Address _____

Date of Birth: _____ Age: _____ Gender: Male Female

Driver's License #: _____ State Issued: _____ Expiration Date: _____

Citizenship: US Other _____ Birth State: _____

Occupation: _____ Length of Employment: _____

Duties: _____ Earned Monthly Income: _____

Do you have a residence in any other state? Yes No If yes, please list state: _____

Marital Status: Single/Never Married Married Divorced Widowed

Spouse's Name: _____ Spouse's Date of Birth: _____

What is the Reason for the Sale of this Policy? _____

Has this policy ever been marketed in the secondary insurance marketplace? Yes No

Have there been any offers made on this policy? If yes, give amount. Yes \$ _____ No

What if the name of the Funding Entity that made that offer? _____

Do you have an expected settlement payout range? If yes, give amount. Yes \$ _____ No

First Policy Information *(Please enclose a copy of your insurance policy)*

Name of Insurance Company: _____

Carrier's Telephone # () _____ Policy Number: _____

Face Amount:\$ _____ Issue Date: _____ Cash Surrender Value:\$ _____

Premium:\$ _____ Frequency: Annual Semi-Annual Quarterly Monthly

Type of Policy: Individual Survivorship Group Converted

If Individual, indicate type: Term Whole Life Universal Life Variable

Policy Owner Information

Name *(If other than insured)*: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home # () _____ Work # () _____ Cell # () _____

Social Security #: _____ Date of Birth: _____ Age: _____

Gender: Male Female Marital Status: Single/Never Married Married Divorced Widowed

If Trust/Corporate Owned, Complete Name: _____

Trustee/Officer Name: _____ Trust Tax ID #: _____

Beneficiary Information

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Second Policy Information *(Please enclose a copy of your insurance policy)*

Name of Insurance Company: _____

Carrier's Telephone # () _____ Policy Number: _____

Face Amount:\$ _____ Issue Date: _____ Cash Surrender Value:\$ _____

Premium:\$ _____ Frequency: Annual Semi-Annual Quarterly Monthly

Type of Policy: Individual Survivorship Group Converted

If Individual, indicate type: Term Whole Life Universal Life Variable

Policy Owner Information

Name *(If other than insured)*: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home # () _____ Work # () _____ Cell # () _____

Social Security #: _____ Date of Birth: _____ Age: _____

Gender: Male Female Marital Status: Single/Never Married Married Divorced Widowed

If Trust/Corporate Owned, Complete Name: _____

Trustee/Officer Name: _____ Trust Tax ID #: _____

Beneficiary Information

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Medical History

Do you or have you ever smoked cigarettes? Yes No If yes, date last used _____

Have you used **other** tobacco or nicotine products? Yes No

If you answered yes, please indicate below what type and date last used.

Cigars _____ Chewing Tobacco _____ Snuff _____
 Pipe _____ Nicotine Gum _____ Patch _____

Do you or have you ever consumed alcoholic beverages? Yes No How often? _____

How many drinks would be consumed at once? _____

Have you ever received alcohol/substance abuse treatment? Yes No If yes, when? _____

Do you exercise regularly? Yes No If yes, how often? _____

If you answered yes, describe type of exercise. _____

Private Pilot Yes No Sky Dive Yes No Mountain Climb Yes No
Scuba Dive Yes No Hang Glide Yes No Auto/Motorcycle Race Yes No

Physician Information

Primary Care Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Telephone # () _____ Office Fax # () _____

Specialty Physician Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Telephone # () _____ Office Fax # () _____

Specialty Physician Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Telephone # () _____ Office Fax # () _____

Insured's Family History

Has anyone in your immediate family had the following?		Father	Mother	Siblings
Osteoporosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Allergies		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Members:	Age:*If deceased please indicate age at time of death.	If living, state of health:	If deceased, cause of death:	
Father				
Mother				
Sibling				
Sibling				
Sibling				

I, the undersigned, hereby represent that all of the information contained herein, is true and correct to the best of my knowledge.

Signature of Seller

Name of Agent or Advisor (if applicable)

Printed Name

Agent or Advisor Address Line 1

Printed Name

Agent or Advisor Address Line 2

Witness

Agent or Advisor Phone # and/or e-mail

Signature of Insured

Printed Name

Witness

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**AUTHORIZATION FOR DISCLOSURE OF HEALTH AND POLICY INFORMATION
(HIPAA COMPLIANT)**

The undersigned insured (hereafter referred to as "I", "me" or "my"), authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as follows:

Permission to Obtain Information: I hereby authorize any health plan, physician, nurse, health care professional, hospital, clinic, laboratory, medical facility, insurance company, insurance support organizations (such as MIB, Inc.) or any other health care provider, individual, or institution (each, a "Provider") to provide Life Settlement Advisors, LLC (an Indiana licensed viatical (life) settlement broker), its authorized representatives, and/or any life insurance companies and/or life settlement providers it reasonably needs to communicate with in order to market and/or broker a life insurance policy of which I am the owner or the insured, including those companies' agents, employees, independent contractors, service providers, and representatives (collectively, "LSA"), with any and all medical records and information as to the symptoms, examination, diagnosis, treatment and prognosis with respect to any physical or mental condition, including HIV/AIDS infections, sexually transmitted diseases, psychiatric conditions (excluding psychotherapy notes), and drug, alcohol, or tobacco abuse, of or relating to the insured.

Disclosure, Inspection, and Copying of Records: This authorization allows for the disclosure, inspection, and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatments or hospitalization of the insured, including but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or physician notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

Release of Policy Information: I understand and acknowledge that the information authorized for release may also include life insurance policy information, including but not limited to, applications, forms, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my insurance company to furnish LSA with any information herein described.

Nature of Information Collected: I understand that the information collected under this authorization will be used by LSA for the distribution to insurance carrier(s) and settlement companies to evaluate my application to sell a life insurance policy of which I am the owner or the insured. I understand that life settlement providers, their medical underwriters, reinsurers or other entities which require health information in order to complete a life settlement transaction will use the information released or obtained pursuant to this authorization for the purpose of completing the sale of a life insurance policy of which I am the owner or the insured, and I hereby expressly authorize such use and disclosure of my information made under this authorization.

Duration and Revocation: This authorization shall remain in force until the date of my death, or until the policy is declined, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand I have the right to revoke this authorization in writing, at any time, by sending a written notice of revocation to Life Settlement Advisors, LLC, 748 E. Bates St., Suite #200, Indianapolis, IN 46202. I understand that a revocation is not effective to the extent that any of my Providers have taken action in reliance upon this authorization prior to receiving notice of my revocation, or to the extent that LSA and the Carrier(s) have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse, or health care plan, and any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Life Settlement Advisors, LLC will protect the privacy of health insurance in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508(c)(1)(iv) of the HIPAA. I understand that my Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Life Settlement Advisors, LLC and the carrier(s) may not be able to process my application. I understand that I have a right to receive a copy of this authorization, and I agree that a photocopy or facsimile of this authorization shall be valid as the original. I also acknowledge receipt of Disclosure Notice to Applicants for Insurance. I certify that this authorization is written in plain language, and I am executing and delivering this authorization freely and unilaterally as of the date written below. If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

This Authorization Signed at _____ this _____ day of _____, 20 _____.

Insured Name

Insured Signature

Broker

Witness