



Life Insurance For Life
professional. trusted. proven.

If policy owner is different than above

| | | |
|--|--|-----|
| Policy Owner (if other than insured) | | |
| Name of Trustee | SS or Tax ID # | |
| Current Address | | |
| City | State | ZIP |
| Day Telephone # | Night Telephone # | |
| Marital Status: <input type="checkbox"/> Male <input type="checkbox"/> Female | Dependent Children: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you ever been or are you now a party to bankruptcy? <input type="checkbox"/> Yes (If yes, please attach all discharge papers) <input type="checkbox"/> No | | |
| ***Please list any additional owners or Trustees on a separate sheet. | | |

Life Insurance Policy Information

| | |
|--|--------------------------|
| Name of Insurance Company | |
| Policy Number | Date of Issue |
| Coverage/Face Amount | Amount of Premium |
| Date the last premium was paid | Date next premium is due |
| Type of Policy: <input type="checkbox"/> Term <input type="checkbox"/> Whole Life <input type="checkbox"/> Universal Life <input type="checkbox"/> Other | |
| Loans | Current Surrender Value |
| Has this Policy ever lapsed? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| What is the Reason for the Sale of this Policy? | |

Fraud Notice

"Any person who knowingly presents false information in an application for insurance or an application for a viatical settlement contract may be guilty of a crime and may be subject to fines and confinement in prison."



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Disclosure Notice and Advice to Policy Owner (Viator) and Insured

1. 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 some or all of the 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. The viator has the unconditional right to rescind a viatical settlement contract within fifteen days after the receipt of the viatical settlement proceeds by the viator, conditioned on the return of such proceeds.
6. The viator shall be provided with the name, business address and telephone number of the independent third-party escrow agent and has the right to receive copies of the relevant escrow or trust agreements or documents.
7. The viatical settlement provider company, not the viator, may compensate LifeInsuranceForLife.com 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: $3\% \times \$100,000$ (face value) = \$3,000.



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Signatures

I/We understand that LifeInsuranceForLife.com has a duty to find the best offer available for my/our life insurance policy (ies). Therefore, I /we hereby grant to LifeInsuranceForLife.com the exclusive right to broker my/our life insurance policy (ies) which may only be terminated upon sixty (60) days prior written notice.

I/We agree that this application will become part of my/our viatical settlement contract if my/our life insurance policy is purchased. I/We agree that all of the information provided in this application is material and represent and warrant that all of the information is true and correct to the best of my/our knowledge. I/We acknowledge that I/We have read and understand the contents of the DISCLOSURE NOTICE.

Signature of Insured 1 Signature Policy Owner (Viator) - *(if other than insured)*

Printed Name of Insured 1 Date Printed Name Policy Owner (Viator) Date

Signature of Insured 2 Signature of Policy Owner (Viator) 2 - *(if applicable)*

Printed Name of Insured 2 Date Printed Name of Policy Owner (Viator) 2 Date

Signature of Witness Signature of Broker or Provider

Printed Name of Witness Date Printed Name of Broker or Provider Date



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**AUTHORIZATION FOR DISCLOSURE OF POLICY INFORMATION AND
PROTECTED HEALTH 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 ("PHI") as follows:

1. I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, an "Authorized Discloser") to provide **LifeInsuranceForLife.com** and/or its authorized representatives, my life insurer (collectively, the "Authorized Recipient") with any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, drug or alcohol abuse, of or related to the insured.

2. 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, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control. This authorization shall apply to any and all of the insured's health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

3. Release of Policy Information. I understand 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 life insurance company to furnish LifeInsuranceForLife.com with any information herein described above.

4. I understand that viatical settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such PHI to complete a viatical settlement contract transaction or in order to sell a viatical settlement contract (each an "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this authorization. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy of this facsimile of this authorization shall be valid as the original.

5. I agree that this authorization shall remain valid for the life of the undersigned (or the last to survive of the undersigned if more than one signatory) or until the policy lapses without the possibility of reinstatement, whichever is earlier, absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under.

6. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser 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 Discloser; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving written notice of my revocation.



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7. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization: I understand that this authorization is voluntary and I am not required to sign. No Authorized Discloser 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 Discloser 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 as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

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Authorized Disclosers

Signature of Insured 1 Signature Policy Owner (Viator) - (if other than insured)

Printed Name of Insured 1 Date Printed Name Policy Owner (Viator) Date

Signature of Insured 2 Signature of Witness

Printed Name of Insured 2 Date Printed Name of Witness Date

Signature of Witness

Printed Name of Witness Date