Settlements For Life, LLC
5350 Poplar Avenue, Suite 550
Memphis, TN 38119

Telephone: 901.683.5558
Toll Free: 877.588.5558
Fax: 901.683.5531

LIFE SETTLEMENT APPLICATION

Confidential Personal and Insurance Information

1. Personal Data of the Insured

Name of Insured:____ Social Security #:____________________

Current Address:____

City:______________________ State:______________ Zip:____________ County:______________

Telephone Number(s): Daytime (   )____________________ Evening (   )________________________

Date of Birth:________________ Marital Status:______________ Sex: ☐ Male ☐ Female

Dependent Children: ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No If No, date last worked:____________________________

Have you been party to a bankruptcy since the policy issue date? ☐ Yes ☐ No

If policy owner is different than above:

Name of Owner:____ Social Security #:____________________

Current Address:____

City:______________________ State:______________ Zip:____________ County:______________

Telephone Number(s): Daytime (   )____________________ Evening (   )________________________

Date of Birth:________________ Marital Status:______________ Sex: ☐ Male ☐ Female

Dependent Children: ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No If No, date last worked:____________________________

Have you been party to a bankruptcy since the policy issue date? ☐ Yes ☐ No

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2. *Life Insurance Policy Information*

Please enclose a copy of the policy and please complete the following:

Name of Insurance Company:____

Policy Number:____

Date Policy was Issued:____________________ Coverage/Face Amount: $____________________

Amount of Premium: $____________________ How frequently is premium paid?____________________

Type of Policy: ☐ Term ☐ Whole Life ☐ Universal Life ☐ Other____________

Beneficiary(ies) and Relationship to the Owner of the Policy: ____________________________

____

____

3. *Medical History of the Insured*

Please give a brief description of your medical condition:________________________________

____

____

Name of Physician seen for this medical condition:

Name of Physician:____

Address:______________________________ Telephone: ( )____________________

City:__________________________ State:____________________ Zip:__________

Who is your primary or family physician? (if different than above)

Name of Physician:____

Address:______________________________ Telephone: ( )____________________

City:__________________________ State:____________________ Zip:__________

If there are any other physicians that have treated you in the last three years, you may attach an additional page including their full name, address, and telephone number.

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How did you hear about Settlements For Life, LLC? ______________________________

____

Signature of Policy Owner	Printed Name	Date

It is a crime to knowingly provide false, incomplete or misleading information in an application for insurance or an application for a viatical or life settlement contract with intent to defraud. Penalties include imprisonment, fines and denial of insurance benefits.

IMPORTANT DISCLOSURES FOR LIFE SETTLEMENT APPLICANTS

All medical, financial, personal information solicited or obtained by a life settlement provider or life settlement broker about an owner and insured, including the owner's and 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 between the owner and the life settlement 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 the funds for the purchase of the policy. You may be asked to renew your permission to share information every two years.

1. There may be possible alternatives to life settlement contracts, including any accelerated death benefits offered under the owner's life insurance policy;

2. Some or all of the proceeds of the life settlement may be free from federal income tax and from state franchise and income taxes. You should seek assistance from a professional tax advisor to determine the tax consequences of selling your life insurance policy;

3. Proceeds of the life settlement could be subject to the claims of creditors;

4. Receipt of the proceeds of a life settlement may adversely affect the owner's eligibility for Medicaid or other government benefits or entitlements. You should obtain advice from the appropriate government agency;

5. All life settlement contracts entered into in Tennessee shall provide the owner with an unconditional right to rescind the contract for at least thirty (30) calendar days from the date of contract or fifteen (15) days upon receipt of the life settlement proceeds, whichever is less. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded, subject to repayment to the life settlement provider of all life settlement proceeds;

6. Funds will be sent to the owner within two (2) business days after the life settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to the life settlement contract; and

7. 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, to be forfeited by the owner. You should seek assistance from a financial advisor to determine what rights or benefits under the policy or certificate will be forfeited by the owner.

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AUTHORIZATION TO RELEASE POLICY INFORMATION

I, ______________________________ , the policy owner hereby authorize ______________________
(Name of the Policy Owner)

______________________________ , the issuer of that certain insurance policy number # ____________________
(Name of the Insurance Company) (Policy Number)

____________ insuring the life of ______________________________ to release to Settlements
(Name of Insured)

For Life, LLC, or its authorized representative(s) and prospective Life Settlement Provider companies, any and all information concerning this policy. A photocopy or facsimile of this document shall be as valid as the original.

X______________________________ ______________________________
Policy Owner's Signature Social Security # or Tax ID #

______________________________ ______________
Type or Print Name Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any physician, medical practitioner, hospital, or medically-related facility, insurance company, or other institution or person(s) having any of my medical records, to release all, by facsimile and/or mail, any such medical records to Settlements For Life, LLC, prospective Life Settlement provider companies, and/or their authorized representative(s).

Medical records shall include all past, present, or future medical information or knowledge of medical information, medical reports, physical examination reports, hospital reports, laboratory reports, or x-ray reports relating to me or my health, including psychological information.

This Authorization shall be valid until, and shall expire, ninety days after the date of this authorization.

A photocopy and/or facsimile of this Authorization shall be as valid as the original.

X____ ____________________X

Insured's Signature Date

____ ____________________

Type or Print Name Social Security

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, 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. Classes of Persons Authorized to Disclose My Prtected 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 Settlements For Life, LLC, prospective provider companies, and its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss re-insurers, credit enhancers, service providers or other representatives (each, an Authorized Recipient).

3. Description of 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 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.

4. Expiration of Authorization:

This authorization shall remain valid until, and shall expire, ninety days from the date of this authorization.

5. 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.

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 re-disclosure 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 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

____
Print or Type Name of Individual

Date: ______________________________

____
Signature of Personal Representative of Individual

Description of Personal Representative's Authority:

____
(Power of Attorney, Guardian ad Litem or similar status)

Date: ______________________________