# LifeSettlementContracts.com SAMPLE APP #1

# APPLICATION FOR LIFE INSURANCE SETTLEMENT

## PERSONAL INFORMATION

INSURED NAME | DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER

CURRENT HOME ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE NUMBER (DAY) | TELEPHONE NUMBER (EVENING)

☐ Single ☐ Married ☐ Widowed ☐ Divorced

PLEASE CHECK MARITAL STATUS ABOVE

INSURED'S DRIVERS LICENSE NUMBER & STATE | MALE/FEMALE | PLACE OF BIRTH

REASON FOR SALE

## LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY | POLICY NUMBER | ISSUE DATE

FACE AMOUNT | TOTAL POLICY LOAN | CASH SURRENDER VALUE

ANNUAL PREMIUM PAYMENT | NEXT PREMIUM DUE DATE

LAST PREMIUM PAID DATE | AMOUNT PAID

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

PREMIUM MODE

☐ Term ☐ UL ☐ SUL ☐ SWL ☐ VUL ☐ Other

TYPE OF POLICY

☐ Individual ☐ Group ☐ Converted Group

GROUP OR INDIVIDUAL POLICY

*Policy Owner*

NAME OF POLICY OWNER(S) | SOCIAL SECURITY NUMBER OR TAX ID NUMBER

NAME OF PRESIDENT (IF CORPORATE OWNDED) | NAME OF CORPORATE SECRETARY

NAME OF TRUSTEE(S) (IF TRUST OWNED) | DATE OF TRUST

ADDRESS

CITY | STATE | ZIP

If individually owned, has policy owner ever been? (Check all that apply)

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Bankrupt

If more than one policy is being submitted, please attach an additional page including policy owner(s) and life insurance policy information as requested above.

## MEDICAL INFORMATION

Please provide a brief description of your medical condition and the reason you are considering a Life Settlement:

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*First Insured*

NAME OF PRIMARY PHYSICIAN TELEPHONE WITH AREA CODE

ADDRESS

CITY STATE ZIP

NAME OF SPECIALIST PHYSICIAN SPECIALTY TELEPHONE WITH AREA CODE

ADDRESS

CITY STATE ZIP

### *Second Insured*

NAME OF PRIMARY PHYSICIAN TELEPHONE WITH AREA CODE

ADDRESS

CITY STATE ZIP

NAME OF SPECIALIST PHYSICIAN SPECIALTY TELEPHONE WITH AREA CODE

ADDRESS

CITY STATE ZIP

If there are any other physicians who have treated you in the last five years, please attach an additional page including full name of physician(s), specialty, address and telephone number with area code.

SIGNATURE OF INSURED DATE

SIGNATURE OF POLICY OWNER DATE

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## ADDITIONAL PHYSICIAN PAGE

| NAME OF SPECIALIST PHYSICIAN | SPECIALTY | TELEPHONE WITH AREA CODE |
|---|---|---|

ADDRESS

| CITY | STATE | ZIP |
|---|---|---|

| NAME OF SPECIALIST PHYSICIAN | SPECIALTY | TELEPHONE WITH AREA CODE |
|---|---|---|

ADDRESS

| CITY | STATE | ZIP |
|---|---|---|

| NAME OF SPECIALIST PHYSICIAN | SPECIALTY | TELEPHONE WITH AREA CODE |
|---|---|---|

ADDRESS

| CITY | STATE | ZIP |
|---|---|---|

| NAME OF SPECIALIST PHYSICIAN | SPECIALTY | TELEPHONE WITH AREA CODE |
|---|---|---|

ADDRESS

| CITY | STATE | ZIP |
|---|---|---|

| SIGNATURE OF INSURED | DATE |
|---|---|

| SIGNATURE OF POLICY OWNER | DATE |
|---|---|

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

**Patient's (Insured) Name:** ____________________________________________________________________________________

**Date of Birth:** __________________________ **Social Security Number:** ______________________________________

I, the undersigned, hereby authorize the disclosure of my protected health information as follows:

1. **Classes of Persons Authorized to Disclose My Protected Health Information:** I authorize any physician, medical practitioner, physician practice group, hospital or medical related facility, health care provider or other institution or person(s) having any medical records, charts, X-rays, laboratory work or similar information regarding my health ("Authorized Disclosure"), to release and disclose such information ("Protected Health Information") as provided in this authorization. I authorize each Authorized Disclosure to rely upon a photographic or facsimile copy or other reproduction of this document.

2. **Persons Authorized to Receive My Protected Health Information:** I authorize my Protected Health Information to be released and disclosed by each Authorized Discloser under this authorization to **Life Settlement Company** any of its principals, employees, agents or other authorized representatives and/or their successors, assigns, designees and affiliated entities (collectively, the "Authorized Recipient").

3. **Description of Protected Health Information Authorized for Disclosure and the Purpose for such Disclosure:** This authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including, but not limited to, the following:

   Physician's/nurse's notes;
   Examination summaries;
   Reports and Orders;
   Medication and Prescription Drug records;
   Radiology, pathology and other laboratory or test reports; and
   Other information/documentation included in a medical file.

   This information and all disclosures of my Protected Health Information made pursuant to this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible sale of any and all life insurance policies under which my life is insured and (2) to verify, track and monitor my health and medical status and condition in connection with any and all life insurance policies under which any life is insured that are sold.

4. **Expiration of Authorization:** This Authorization shall remain valid until and shall expire on, the date of my death.

5. **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Disclosure by notifying such Authorized Discloser or my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated 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 notice of my revocation or if this authorization was obtained.

I acknowledge and 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 "HIPPA Privacy Regulations"). I further understand that, as a result of this authorization, my Protected Health Information disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and that my Protected Health Information that is disclosed to the Authorized Recipient may no longer be protected by the HIPPA Privacy Regulations.

I certify that I am executing and delivering this authorization freely, voluntarily and unilaterally as of the date written below. I further certify that I understand this authorization written in plain language and that I have retained a copy of this signed authorization for future reference.

_______________________________________________ ______________________________

Signature of Patient (Insured) Date

_______________________________________________

Printed Name of Patient (Insured)

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**AUTHORIZATION FOR RELEASE OF INSURANCE POLICY INFORMATION**
**(Signed by the Policy Owner/Applicant)**

I hereby authorize my insurance company to release directly to Life Settlement Company and/or its authorized representatives with any information and forms in connection with my policy (including, but not limited to, verification of coverage, any illustrations or any conversions, thereof). As per my specific instructions, as the Policy Owner, please fax the requested information to Life Settlement Company directly and forward a copy to me.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original.

I agree that this authorization shall remain valid for three years, absent any of provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted, thereunder.

______________________________________________________________________________
NAME OF POLICY OWNER(S) SIGNATIRE DATE

______________________________________________________________________________
ADDRESS SOCIAL SECURITY NUMBER OR TAX ID NUMBER

______________________________________________________________________________
CITY STATE ZIP

______________________________________________________________________________
POLICY NUMBER 1 INSURANCE COMPANY

______________________________________________________________________________
POLICY NUMBER 2 INSURANCE COMPANY

______________________________________________________________________________
POLICY NUMBER 3 INSURANCE COMPANY

______________________________________________________________________________
NAME OF WITNESS SIGNATURE DATE

______________________________________________________________________________
NAME OF WITNESS SIGNATURE DATE

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# PERSONAL ACKNOWLEDGEMENT

I represent and warrant the information contained in this application is correct and accurate and you may rely thereon and that I will immediately notify Life Settlement Company of any changes in the information. I further give my consent to Life Settlement Company and its agents to release this application and all information gathered while processing it as necessary for the sole purpose of soliciting the sale of my life insurance policy. I acknowledge that I am submitting this application to Life Settlement Company to broker the sale of my life insurance policy and that Life Settlement Company, is under no obligation to purchase my policy. I acknowledge I may be contacted by Life Settlement Company regarding information contained in this application.

I understand that some or all of the proceeds from a Life Insurance Settlement may be taxable and that I am encouraged to consult with an attorney or tax advisor concerning this transaction. I also acknowledge that neither Life Settlement Company, nor any of its representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction

I acknowledge that any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

_______________________________________________________________________________

NAME OF THE POLICY OWNER(S) SIGNATURE DATE

_______________________________________________________________________________

NAME OF THE WITNESS SIGNATURE DATE

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# DISCLOSURE NOTICE: A NOTICE TO APPLICANTS

**We at Life Settlement Company, a life settlement company, do hereby advise you that:**

1. There are possible alternatives to a life settlement contract including, but not limited to, accelerated death benefits, loans secured by the policy, and surrender of the policy for cash value offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance carrier and/or policy. We recommend that you obtain information from your insurance company or your advisors regarding the options available to you.

2. Some or all of the proceeds of your settlement may be taxable under federal income tax and/or state franchise and income tax laws. Assistance should be sought from a professional tax advisor. We make no representation and give no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

3. Some or all of your life settlement proceeds may adversely affect your eligibility for social security income, public assistance and public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.

4. The proceeds of a life settlement could be subject to the claims of creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.

5. If your policy contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of a spouse, dependents, or others, there may be a loss of coverage. We urge you to contact the issuer of your life insurance policy for information on these provisions.

6. Entering into a life settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends and may cause other rights or benefits, including conversion rights and waiver or premium benefits that may exist under the policy forfeited by you.

7. All medical, financial, or personal information solicited or obtained by The Life Settlement Company about the insured, including the insured's identity or the identity of family members, a spouse or significant other may be disclosed as necessary to effect the life settlement between you and The Life Settlement Company. If the insured is asked to provide this information, the insured will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. The insured may be asked to renew his or her permission to share information every two years.

8. One consequence of selling your insurance policy will be the loss of the death benefit payable to the current beneficiary(ies).

9. Life Settlement Company will be compensated. The settlement provider company, not the insured, will compensate Life Settlement Company 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: 6% x $100,000 (face value) = $6,000. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.

10. You have the right to rescind your settlement before the earlier of thirty (30) calendar days after the date upon which the settlement contract is executed by all parties or fifteen (15) calendar days after the receipt of the settlement proceeds. If exercised, rescission is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans and loan interest to the settlement provider is made within the rescission period. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded, subject to repayment of all settlement proceeds and any premiums, loans and loan interest to the settlement provider. Funds will be sent to you within three (3) business days after the settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to the settlement contract.

11. The insured may be contacted by the settlement provider or its authorized representative for the purpose of determining the insured's health status. This contact shall be limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

| | | |
|---|---|---|
| NAME OF POLICY OWNER(S) | SIGNATIRE | DATE |
| ADDRESS | SOCIAL SECURITY NUMBER OR TAX ID NUMBER | |
| CITY | STATE | ZIP |
| NAME OF THE WITNESS | SIGNATURE | DATE |

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