SETTLEMENT APPLICATION - (PLEASE PRINT OR TYPE)

A. PERSONAL INFORMATION INSURED

____
Insured's Name   Date of Birth   Social Security Number   Sex (male/female)

____
2nd Insured's Name   Date of Birth   Social Security Number   Sex (male/female)

____
Address   Phone Number

____
City   State   Zip Code

Marital Status: __Single/Never Married __Married __ Divorced __ Separated __Widow/Widower
If Married Spouse's Name __________________

B. PERSONAL INFORMATION OWNER –If other than insured

____
Owner's Name   Date of Birth   Social Security/Tax ID Number

____
2nd Owner's Name   Date of Birth   Social Security/Tax ID Number

____
Address   Phone Number

____
City   State   Zip Code

Marital Status: __Single/Never Married __Married __ Divorced __ Separated __Widow/Widower
If Married Spouse's Name __________________

Is the policy owner a defendant in any suits or legal actions? Yes _____ No _____

Has the policy owner ever declared bankruptcy? Yes _____ No _____
Drivers license # _______________ State of Issue _________

Complete if Policy owner is a Trust, Corporation, Partnership, LLC or Other Entity

____
Trust Situs/ State of Incorporation or Domicile

____
Name of signatory   Title (Trustee, Corporate Officer, Partner, etc.)

____
Name of signatory   Title (Trustee, Corporate Officer, Partner, etc.)

C. MEDICAL INFORMATION

Insured Medical History ____

2nd Insured Medical History____

____

Primary Physician Telephone Number

____

Specialist Telephone Number

D. LIFE INSURANCE INFORMATION

____

Insurance Company Policy Number Face Amount

____

Date of Issue Policy Type (WL, UL, SUL, Term, etc…) Current Premium

____

Initial Policy Owner (at time of Issuance) Name of current policy owner (If different)

Has policy beneficiary changed since the policy was issued ? ____Yes ____No

If yes, why? ____

____

Name of initial Beneficiary(s) Relationship(s) to insured

____

Name of current beneficiary(s) (If different) Relationship(s) to insured

What was the insured's and policy owner's original purpose for buying the policy? ________________________

____

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 _______

____

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. ______________________________________

____

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, what is name of lender? ___________________________ Principal loan amount __________________

Loan Maturity balance (payoff amount) ____________________ Loan Maturity date ______________________

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 parties, including but not limited to: grantor(s), trustee(s), and beneficiary(ies).

____

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

____

Name nature of the interest date and manner interest was obtained relationship to insured

For additional policy and/or physician information, please provide a supplementary page.

For Agent Use: If available, please include the following: 1) Current in force Illustration to maturity.

2) Current APS (if not within the last 90 days, please provide physician information in Section C).

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, 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 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 HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each HCP to disclose my PHI under this authorization to Life Insurance Settlements, Inc. ("LIS") and any of its affiliates, to any successor or assign of LIS or any of its affiliates and to any director, officer, employee, agent, independent contractor, consultant, medical or life expectancy underwriter (including, without limitation, Examination Management Services, Inc.), lender, financing entity, stop-loss reinsurer, service provider or other representative of LIS or any such affiliate, successor or assign (each, an "Authorized Recipient").

3. 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 any 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; (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 therefor; and (3) to develop and use indices that do not personally identify individuals related to actual and anticipated longevity, mortality, life expectancies and/or similar measures.

4. Expiration: This authorization shall remain valid until, and shall expire, one year after 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 HCP by notifying such 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 HCP; provided, that, any revocation of this authorization shall not apply to the extent that an 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 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.

____
Signature of Insured Date

____
Print or Type Name of Individual Date

____
Signature of Personal Representative of Individual Date

Description of Personal Representative's Authority:
____
(Power of Attorney, Guardian ad Litem or similar status)

Life Insurance Information Release Form

Life insurance policy number ________________________ issued by _____________________________ (Insurance Company), is owned by _____________________________, and insured the life of _____________________________.

I authorize the release to Life Insurance Settlements, Inc. (LIS) or its designee, any or all information concerning the above policy.

I authorize LIS to share this information with life settlement providers, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for life settlements, and / or life and health insurance policies.

_____________________________________ Policy Owner Signature

__________________________ Date

____________________________________ Type or Print Name

__________________________ Social Security Number