



LIFE SETTLEMENT FORMS INSTRUCTIONS

1. **LIFE SETTLEMENT INFORMATION FORM**
 - Form to be signed by the Policy Owner(s) and Insured(s)
 - If owned by a Trust or a Corporation, the Trustee or Officer must sign as Owner

2. **LIFE INSURANCE POLICY INFORMATION RELEASE AUTHORIZATION**
 - Form must be signed by both the Policy Owner and the Insured

3. **MEDICAL INFORMATION RELEASE AUTHORIZATION [HIPAA Compliant]**
 - Form must be signed by the Insured only

4. **DISCLOSURE STATEMENT**
 - Form must be signed by the Policy Owner and the Agent

5. **COPY OF THE INSURANCE POLICY** (including a copy of the original application)

6. **COPY OF THE TRUST DOCUMENT** (if policy owned by a Trust)

Once you have completed the forms and you have all the necessary items together, **fax the forms to us at 203-621-3340.**



LIFE SETTLEMENT INFORMATION FORM

INSURED'S INFORMATION

_____ Name	_____ Date of Birth	_____ M/F
_____ Street Address	_____ Social Security Number	
_____ Street Address (<i>cont</i>)	_____ If Married, spouse's name	
_____ City	_____ State	_____ Zip Code
_____ Home Phone		_____ Work Phone

Additional Insured (if Survivorship Policy)

_____ Name	_____ Date of Birth	_____ M/F
_____ Street Address	_____ Social Security Number	
_____ Street Address (<i>cont</i>)	_____ If Married, spouse's name	
_____ City	_____ State	_____ Zip Code
_____ Home Phone		_____ Work Phone

OWNER'S INFORMATION (if different from the Insured)

_____ Name	_____ Social Security Number / Tax ID
_____ Street Address	_____ Phone Number
_____ City	_____ Relationship to Insured
_____ State	
_____ Zip Code	



HEALTH STATUS OF INSURED(S)

In order to make the life settlement process as efficient as possible, LifeOptions will be requesting complete medical records from ALL Doctor and Hospital visits in the last 10 years.

Please include your Primary Care Physician and any Specialists you may have seen such as a Cardiologist, Urologist, and Oncologist, etc.

If needed, please write any additional doctors on a separate page.

<hr/> <p>Doctor's Name</p> <hr/> <p>Clinic</p> <hr/> <p>Street Address</p> <hr/> <p>City State Zip Code</p> <hr/> <p>Phone</p> <hr/> <p>Specialty</p>	<hr/> <p>Doctor's Name</p> <hr/> <p>Clinic</p> <hr/> <p>Street Address</p> <hr/> <p>City State Zip Code</p> <hr/> <p>Phone</p> <hr/> <p>Specialty</p>
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<hr/> <p>Doctor's Name</p> <hr/> <p>Clinic</p> <hr/> <p>Street Address</p> <hr/> <p>City State Zip Code</p> <hr/> <p>Phone</p> <hr/> <p>Specialty</p>	<hr/> <p>Doctor's Name</p> <hr/> <p>Clinic</p> <hr/> <p>Street Address</p> <hr/> <p>City State Zip Code</p> <hr/> <p>Phone</p> <hr/> <p>Specialty</p>
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POLICY INFORMATION *(complete one page for each policy)*

Insurance Carrier		Policy Issue Date	
Policy Number		Date of Last Premium Payment	
Face Amount		Date of Next Premium Payment	
Premium Amount		Premium Mode	
Cash Value		Loans <i>(If Applicable)</i>	
Policy Type	Whole Life Term Life	Universal Life	Variable Life Joint Survivorship

Does the Insured plan on obtaining a new life insurance policy? Yes No

Is there a lien against the policy? Yes No

Was this policy premium financed? Yes No

FRAUD NOTICE

The presentation of false or fraudulent material to LifeOptions, LLC and/or the company that issued the life insurance policy could be a crime and may be subject to fines and confinements in prison. In some states, LifeOptions, LLC is required by law to report suspected insurance fraud. LifeOptions, LLC will report to the appropriate authorities all suspected fraudulent activity that it discovers related to the life insurance policy and/or this Information Form.

SIGNATURES

I/We agree that all of the information is true and correct to the best of my/our knowledge.

OWNER'S Signature

JOINT OWNER'S Signature *(if applicable)*

INSURED'S Signature

SECOND INSURED'S Signature *(if applicable)*

Date

Date



LIFE INSURANCE POLICY RELEASE AUTHORIZATION

Insured

Policy Owner

Policy Number

Life Insurance Carrier

I hereby authorize the above-referenced life insurance company and/or any other entity or person that has information related to the above-referenced life insurance policy, to release such information to and reply immediately to any written, telephonic or other request for information or documents required by LifeOptions, LLC and/or its authorized representatives, successors, assignees, designees and/or affiliated entities, pertaining to the above-referenced policy, including, but not limited to the following:

- A fully-completed Verification of Coverage (VOC) form
- A complete copy of the above-referenced life insurance policy, including the application (and also including the master policy and employee certificate for group policies)
- Policy Illustrations
- Change of ownership forms, change of beneficiary forms, collateral assignment forms absolute assignment forms and any other requested form
- Premium and Annual Statement information

I understand that this Authorization for the Release of Life Insurance Policy Information will be used to gather information about the above-referenced life insurance policy. I agree that this Authorization for the Release of Life Insurance Policy Information shall remain valid and in force for a period of two (2) years and that a photocopy or facsimile of this document is as valid as an original. This document may be signed in counterparts.

Policy Owner Signature

Policy Insured Signature *(if different from Policy Owner)*

Print Name

Print Name

Date

Date



MEDICAL INFORMATION RELEASE AUTHORIZATION

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 ("HIPAA") as follows:

Classes of Persons Authorized to Disclose and Receive 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) ("Authorized Discloser"), having any PHI about me, to release and disclose such information ("Protected Health Information") as provided in this authorization. I authorize each Authorized Discloser to rely upon a photographic or facsimile copy or other reproduction of this document. I authorize my PHI to be released and disclosed by each Authorized Discloser under this authorization to **LifeOptions, LLC** any of its principals, employees, agents, or other authorized representatives and/or their successors, assignees, designees and affiliated entities (collectively, the "Authorized Recipient").

Description and Purpose of Protected Health Information Authorized for 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. This authorization and all disclosures of my PHI 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 my life is insured that are sold.

Expiration of Authorization: This authorization shall remain valid and will expire on the date of my death.

Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of 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 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, my Protected Health Information disclosed by any Authorized Discloser to the Authorized Recipient may be subject to redisclosure by the Authorized Recipient and that my Protected Health Information that is disclosed to the Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization voluntarily and unilaterally as of the date written below and I understand this authorization is written in plain language and that I have retained a copy of this signed authorization.

Patient Signature

Print Patient's Name

Date Signed



DISCLOSURE STATEMENT

1. There may be possible alternatives to life settlement contracts including any accelerated death benefits or policy loans offered under your life insurance policy
2. Some or all of the proceeds of the life settlement may be taxable under federal income tax and assistance should be sought from a professional tax advisor.
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 your eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
5. Entering into a contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the seller. Assistance should be sought from a financial adviser.
6. All medical, financial, or personal information solicited or obtained by a life settlement provider or life settlement broker about an 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 the seller 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 funds for the purchase. You may be asked to renew your permission to share this information every two years.
7. The insured may be contacted by either the life settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contract is limited to once every three months following the date the life settlement proceeds are released to the seller if the insured has a life expectancy of more than one year, and no more than once per month following such date if the insured has a life expectancy of one year or less.
8. Brokerage fees for this life settlement transaction will be paid by the buyer and shall not exceed 10% of the face amount of the policy.

I/We acknowledge that I/we have read and understand the contents of this Disclosure Statement.

Policy Owner Signature

Date

Agent Signature

Date

Joint Policy Owner Signature *(if applicable)* Date



LifeOptions_{LLC}

Agent Information

<hr/> <p>Name</p>	<hr/> <p>Email</p>
<hr/> <p>Company</p>	<hr/> <p>Office Phone</p>
<hr/> <p>Address</p>	<hr/> <p>Cell Phone</p>
<hr/> <p>City State Zip Code</p>	<hr/> <p>Fax</p>