

LIFE SETTLEMENT APPLICATION

Policyowner(s)

Name of Policyowner(s) Date(s) of Birth

Driver's License Number(s) Social Security or Tax ID number(s)

Address

City State Zip

Daytime Phone Number Evening Phone Number

Name of President (if corporate owned) Name of Corporate Secretary

Name of Trustee(s) (if trust owned) Date of Trust

Names and ages of children, designated heirs and other dependents (if none, state "None")

Yes No

Have you been party to a bankruptcy since the policy issue date?

Married Divorced Legally Separated Widowed

Marital Status

Yes No If no, what country?

Are you a U.S. Citizen?

Yes No If yes, please list below

Are you the owner of any other inforce life insurance policies?

Company Face Value

Company Face Value

If there are multiple owners, please attach an additional page including full name of owner(s), date of birth, driver's license number, social security or tax ID number, address and telephone number with area code. If more than one policy is being submitted, please attach an additional page including policyowner(s) and life insurance policy information as requested above.

Insured Personal Data

First Insured Name	Date of Birth	Sex
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First Insured Social Security Number	Driver's License Number
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Daytime Phone Number	Evening Phone Number
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Yes No If no, what country?
Are you a U.S. Citizen?

Second Insured Name	Date of Birth	Sex
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Second Insured Social Security Number	Driver's License Number
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Daytime Phone Number	Evening Phone Number
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Yes No If no, what country?
Are you a U.S. Citizen?

Address

City	State	Zip
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Purpose of Transaction

First Insured Medical Condition (brief description)

Second Insured Medical Condition (brief description)

Yes No If yes, please list below.
Do you have any other life insurance policies in force?

Company	Face Value
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Company	Face Value
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Company	Face Value
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Medical Information

First Insured

Name of Primary Physician

Telephone with Area Code

Address

City

State

Zip

Name of Specialist Physician

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.

Second Insured (if joint policy)

Name of Primary Physician

Telephone with Area Code

Address

City

State

Zip

Name of Specialist Physician

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.

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	
<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Premium Mode		
<input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> SUL <input type="checkbox"/> SWL <input type="checkbox"/> VUL <input type="checkbox"/> Other (please specify) Type of Policy		
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
Are there any liens against the policy?		

Referring Advisor/Agent Information

Name of Referring Advisor/Agent	Telephone with Area Code
Address	
City	State
	Zip

The following will be needed to obtain an offer:

- Copy of the insurance policy if available, or a copy of the face page
- Signed authorization for Life Settlement Advisors to obtain medical records for the last five years including family history
- If policyowner has ever been bankrupt, include a copy of the bankruptcy discharge
- If policyowner has ever been divorced, include a copy of the divorce decree

I, the undersigned, hereby represent that all of the information contained herein, is true and correct to the best of my knowledge.

Signature of Insured	Date
Signature of Second Insured	Date
Signature of Policyowner	Date

**AUTHORIZATION FOR DISCLOSURE OF HEALTH AND POLICY 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 ("HIPAA"), as follows:

Permission to Obtain Information: I hereby authorize any health plan, physician, nurse, health care professional, hospital, clinic, laboratory, medical facility, insurance company, insurance support organizations (such as MIB, Inc.) or any other health care provider, individual, or institution (each, a "Provider") to provide Life Settlement Advisors, LLC (an Indiana licensed viatical (life) settlement broker), its authorized representatives, and/or any life insurance companies and/or life settlement providers it reasonably needs to communicate with in order to market and/or broker a life insurance policy of which I am the owner or the insured, including those companies' agents, employees, independent contractors, service providers, and representatives (collectively, "LSA"), with any and all medical records and information as to the symptoms, examination, diagnosis, treatment and prognosis with respect to any physical or mental condition, including HIV/AIDS infections, sexually transmitted diseases, psychiatric conditions (excluding psychotherapy notes), and drug, alcohol, or tobacco abuse, of or relating to the insured.

Disclosure, Inspection, and Copying of Records: 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 of the insured, including but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or physician notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

Release of Policy Information: I understand and acknowledge 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 insurance company to furnish LSA with any information herein described.

Nature of Information Collected: I understand that the information collected under this authorization will be used by LSA for the distribution to insurance carrier(s) and settlement companies to evaluate my application to sell a life insurance policy of which I am the owner or the insured. I understand that life settlement providers, their medical underwriters, reinsurers or other entities which require health information in order to complete a life settlement transaction will use the information released or obtained pursuant to this authorization for the purpose of completing the sale of a life insurance policy of which I am the owner or the insured, and I hereby expressly authorize such use and disclosure of my information made under this authorization.

Duration and Revocation: This authorization shall remain in force until the date of my death, or until the policy is declined, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand I have the right to revoke this authorization in writing, at any time, by sending a written notice of revocation to Life Settlement Advisors, LLC, 748 E. Bates St., Suite #200, Indianapolis, IN 46202. I understand that a revocation is not effective to the extent that any of my Providers have taken action in reliance upon this authorization prior to receiving notice of my revocation, or to the extent that LSA and the Carrier(s) have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse, or health care plan, and any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Life Settlement Advisors, LLC will protect the privacy of health insurance in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508(c)(1)(iv) of the HIPAA. I understand that my Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Life Settlement Advisors, LLC and the carrier(s) may not be able to process my application. I understand that I have a right to receive a copy of this authorization, and I agree that a photocopy or facsimile of this authorization shall be valid as the original. I also acknowledge receipt of Disclosure Notice to Applicants for Insurance. I certify that this authorization is written in plain language, and I am executing and delivering this authorization freely and unilaterally as of the date written below. If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

This Authorization Signed at _____ this _____ day of _____, 20 _____.

Insured Name

Insured Signature

Broker

Witness