ELA Settlement Services, LLC Data Collection Form

Complete the following forms, and mail, fax or email with any relevant documents to:

ELA Settlement Services
1435 Morris Ave. • P.O. Box 3137 • Union, NJ 07083
Fax: 908-810-4159 • Tel 1-800-388-0103 • email: info@execlife.com

After receiving the following information, we will be able to evaluate the opportunity to present you with an offer to purchase your life insurance policy. Please complete the following forms and sign pages in the areas indicated.

INSURED'S INFORMATION

Insured's Name _____

Social Security # _____ - _____ - _____

Street Address (No PO Box) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Fax # _____ E-mail Address _____

Date of Birth _____ Sex ❑ Female ❑ Male

Spouse's Full Name _____

Spouse's Date of Birth _____ / _____ / _____

EMPLOYMENT STATUS

Are you currently retired? ❑ Yes ❑ No Do you work? ❑ Yes ❑ No

Current employer and occupation _____

LIFE INSURANCE POLICY INFORMATION
(please provide for each policy being offered for sale)

Name of Insurance Company _____

Policy Number _____ Face Value $ _____

Policy Issue Date _____ Insuring ❑ Individual ❑ Survivorship

Policy Type - ❑ Universal ❑ VUL ❑ Term ❑ Whole Life ❑ Group

Are there supplemental benefits such as Accidental Death or Double Indemnity provision on the Policy? ❑ Yes ❑ No

If term policy, can it be converted until what date? _____

Did anyone other than the owner pay for or finance premium payments? ❑ Yes ❑ No

Annual Premium _____ Paid ❑ A ❑ SA ❑ Q ❑ M

Next premium due date _____

Owner of Policy _____ Tax ID# _____

Owner Address _____

Phone _____ Fax _____

Complete Trust or Corporation name, and names of Trustee(s) or 2 officers

_____

_____

Beneficiary (ies) _____

Primary Beneficiary Address _____

_____

Reason for selling _____

Has an application for insurance on insured's life/health ever been declined, rated or modified in any way (including this policy)? ❑ Yes ❑ No

If yes, give company and reason _____

_____

Does the insured have plans to purchase new life insurance? _____

Total face value of life insurance NOT being offered for sale herewith _____

MEDICAL

Please list any specific health conditions _____

Has insured smoked: ❑ Cigarettes ❑ Cigars ❑ Cigarillos ❑ Pipe in past 12 months? ❑ No

Does insured use or has ever used alcoholic beverages? ❑ Yes ❑ No If yes, answer the following:

(A) Frequency of use ❑ Daily ❑ Weekly ❑ Monthly ❑ Occasionally

(B) Amount consumed on each occasion _____

(C) Any treatment for alcohol use (including AA treatment) _____

FAMILY HISTORY	Current Age	Deceased?	If deceased, cause and age at time of death
(A) Father	_____	❑ Yes ❑ No	_____
(B) Mother	_____	❑ Yes ❑ No	_____
(C) (Brother) (Sister)	_____	❑ Yes ❑ No	_____
(D) (Brother) (Sister	_____	❑ Yes ❑ No	_____

Please list insured's Primary Care Physician:

1) Name _____
Address _____
City, State, Zip _____
Phone # _____

3) Name _____
Address _____
City, State, Zip _____
Phone # _____
Specialty: _____
Date last seen: _____

Please list Specialists that insured has seen:

2) Name _____
Address _____
City, State, Zip _____
Phone # _____
Specialty: _____
Date last seen: _____

4) Name _____
Address _____
City, State, Zip _____
Phone # _____
Specialty: _____
Date last seen: _____

Attach additional pages if needed. Give a copy of the letter enclosed to the above physicians/specialists (make copies as needed.

FINANCIAL

Has insured applied for or received a pension or compensation because of illness or injury? ❑ Yes ❑ No

If yes, give details of illness or injury: _____

_____

Has owner been a party to a: (check all that apply) ❑ Civil Suit

❑ Bankruptcy ❑ Judgments ❑ Creditor Liens ❑ Tax Liens

Explain any checked answers on a separate page and attach all discharge papers.

Does insured have a living will? ❑ Yes ❑ No

PERSONAL ACKNOWLEDGEMENT

I represent and warrant that the information contained in this data collection form is correct and accurate and you may rely thereon and that I will immediately notify ELA Settlement Services of any changes in the information. I further give my consent to ELA Settlement Services and its agents to release this Data Collection Form and all information gathered while processing it as necessary for the sole purpose of soliciting the purchase of my life insurance policy. I acknowledge that I am submitting this data collection form for ELA Settlement Services to evaluate the purchase of my life insurance policy and that ELA Settlement Services is under no obligation to purchase my policy. I acknowledge I may be contacted by ELA Settlement Services regarding the information contained in this data collection form.

I understand that some or all of the proceeds from a life 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 ELA Settlement Services nor any of its affiliates or representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

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

Owner's signature _____

Typed or printed name _____ Date _____

Witness signature _____

Printed Name _____ Date _____

Insured's Name: _____Social Security: ____ - ____ - ____

Connecticut Disclosure Statement

The Provider must provide these disclosures not later than the date the settlement contract is signed by all parties.

1. That there are possible alternatives to life settlement contracts including, but not limited to, accelerated death benefits offered by the issuer of the life insurance policy;
2. That some or all of the proceeds of a life settlement contract may be taxable, and assistance should be sought from a professional tax advisor;
3. That receipt of the life settlement contract proceeds may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements, and advice should be obtained from the appropriate agencies;
4. That the owner has the right to rescind a life settlement contract for fifteen calendar days after the date such contract is executed by all parties and the owner has received the disclosures specified herein. Such rescission exercised by the owner shall be effective only if both notice of rescission is given to the provider and the owner repays all proceeds and any premiums, loans and loan interest paid by the provider within the rescission period. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the provider;
5. That proceeds from the life settlement contract may be subject to the claims of creditors;
6. That proceeds will be sent to the owner within three business days after the 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 in accordance with the terms of the life settlement contract;
7. That 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, and assistance should be sought from a financial advisor;
8. That the insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is 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;
9. The amount and method of calculating the compensation paid or to be paid to the broker or to any other person acting for the owner in connection with the transaction, wherein the term compensation includes anything of value paid or given;
10. The date by which the funds will be available to the owner and the transmitter of the funds;
11. That the commissioner shall require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process;
12. That the commissioner shall require providers and brokers to print separate, signed fraud warnings on their applications and on their life settlement contracts as follows: "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.";
13. The affiliation, if any, between the provider and the issuer of the insurance policy to be settled;
14. That a broker represents the owner exclusively, and not the insurer, the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;
15. The name, address and telephone number of the provider;
16. The name, business address and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and
17. That a change of ownership could limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.
18. A broker shall provide the owner and the provider with at least the following disclosures not later than the date the life settlement contract is signed by all parties.The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:
    (a.) The name, business address and telephone number of the broker;
    (b.) A full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed life settlement contract;

(c.) A written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contract;

(d.) The name of each broker who receives compensation and the amount of compensation received by said broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract;

(e.) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purpose of this section, "gross offer" or "bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees; and

(f.) That the failure to provide the disclosures or rights described in this section shall be deemed an unfair practice in violation of section 38a-815.

I (We) acknowledge receipt of this Disclosure Statement as well as a separate brochure describing the process of viatical settlements.

_____

Date

_____

Owner's Signature

_____

Owner's Signature

_____

Date

ELA Settlement Services, 1435 Morris Ave, PO Box 3137, Union, NJ 07083

AUTHORIZATION FOR THE RELEASE OF INFORMATION
RELEASE OF POLICY INFORMATION

Please complete only the areas marked with asterisk.

I hereby authorize _____ ,the issuer of Policy Number _____ and/or Certificate Number _____ owned by _____ and insuring the life of _____ , to release to ELA Settlement Services or its authorized agents, a copy of the policy, forms, riders or amendments of this policy. I respectfully request that you reply immediately to any request for information or letters required by ELA Settlement Services or its agents pertaining to this policy or employment information. I agree that this authorization is valid for six (6) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

_____ _____

*Signature of Owner *Printed Name of Owner

_____ _____

*Date Signed *Social Security Number

*Signature of Witness _____

*Printed Name of Witness _____

*Date Signed _____

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AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 as follows:

I authorize any physician, doctor, physician practice group, medical practitioner, nurse, nurse practitioner, hospice, hospital clinic or other medical or medically-related facility, insurance support organization, pharmacy, or any other institution or person ("Authorized Discloser") to provide ELA Settlement Services, LLC, or its designee ("Authorized Recipient") any and all of my PHI as provided under this authorization. This may include information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me.

This authorization allows for the disclosure, inspection, and copying of any and all records, reports, consultations, and/or documents, including any underlying data regarding my care and treatment, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to me, along with any and all medical charts, clinical or doctor's notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, medical records in the possession and control of the Authorized Discloser. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site.

This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition. The Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this authorization.

I understand that I have a right to revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of the revocation in writing and presenting my written revocation in person or by certified mail to such address designated by the respective Authorized Discloser. I understand that the revocation will not apply to information that has already been released in response to 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 care plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations") and that PHI obtained by this Authorization, if re-disclosed by the 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. I agree this authorization is valid for one (1) year from the date of this signature, and that a photocopy or facsimile is as valid as an original.

_____	_____
Signature of patient or legal representative	Date
_____	_____
Printed name of patient	If signed by legal representative, relationship to patient
_____	_____
Signature of witness	Date

AGENT OF RECORD LETTER
FOR LIFE SETTLEMENTS

I, _____ , owner of policy number _____

with _____ insurance company, have agreed

to consider the sale of this policy as a Life Settlement.

My agent of record for the sale of the above mentioned policy is:

_____

and settelment agency of record is ELA Settlement Services, LLC.

_____ _____

Signature of Owner Date

_____

Address

_____ _____

Witness Date

_____

Printed Name of Witness

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AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION

I hereby authorize any physician, medical practitioner, hospice, clinic or other medical or medically related facility, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide ELA Settlement Services, LLC and/or its authorized representatives or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the Insured.

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 treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession or control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that funding sources and their medical underwriters and/or contingency reinsurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policy(ies) on which I am the owner or Insured, and I hereby authorize such use and disclosure. 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 the life time of the undersigned (or the last to survive of the undersigned if more than one signatory), 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 thereunder.

_____	_____	_____	_____
Signature of Insured	Date	Signature of Policy Owner	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date
_____	_____	_____	_____
Signature of Witness	Date	Signature of Witness	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date

CHECKLIST FOR DATA COLLECTION FORM PACKAGE

This checklist was designed to help you ascertain if you have completed all pertinent items in order to expedite processing of the life settlement.

The following items must be received by ELA Settlement Services in order for the policy to be processed:

❑ Data Collection Form must be filled out completely, signed and witnessed. Anything that is not applicable, mark "N/A."

❑ The release forms for Medical and Policy Information must be signed, witnessed and dated by appropriate parties as indicated.

❑ The Notice of Disclosure must be signed and dated.

❑ 5 years of medical records for attending physicians, current within 30 days of completing the Data Collection form.

❑ Agent of Record Letter signed, dated and witnessed.

❑ Insured's photo ID - Accepted forms of identification are photocopies of a driver's license or passport. Identification must be current not expired.

❑ Complete copy of the insurance policy. If this is not available immediately, please make a note for us on the Data Collection Form and forward as soon as possible.

❑ Current in-force illustration from the insurance company with Data Collection Form showing the following:

- ❑ Universal Life – minimum premium payment to age 95.
- ❑ Term – proposed conversion illustration to Universal showing a minimum payment to age 95.
- ❑ Whole Life – run a natural vanish premium illustration to age 95.

❑ Owner and Beneficiary (ies) of the policy.

If owner/beneficiary is a trust, we need:

- ❑ Copy of trust and Tax ID#
- ❑ Trustee (s) must sign the policy information release form

If owner/beneficiary is a corporation, we need:

- ❑ Complete name and address of corporation.
- ❑ Corporate resolution showing current authorized officers.
- ❑ Two officers must sign the policy information release form.

In addition, please send the "Letter to Physician" directly to the physicians/ specialists listed on the application.

FOR AGENTS ONLY: Broker _____

Representing Agent _____

Address _____

Phone _____ Fax _____

Is the representing agent the agent of record on the policy? _____

Agent Signature _____ Date _____

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