ELA SETTLEMENT SERVICES, LLC
1435 Morris Avenue
Union, NJ 07083
800-388-0103 908-851-0770 908-810-4159 (Fax)

TX Viatical/Life Settlement Application Supplement

Receipt of a viatical settlement* or life settlement may affect your eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependant Children (AFDC), supplementary social security income (SSI), and drug assistance programs. The money you receive for your life insurance policy may also be taxable. Before completing a viatical or life settlement contract, you are urged to consult with an attorney, accountant, estate planner, financial planning advisor, your insurer or insurance agent, tax advisor, or a social service agency concerning how receipt of a payment will affect you, your family, and your spouse's eligibility for public assistance. For more information about viatical or life settlements generally, contact Texas Department of Insurance at 1-800-252-3439.**

> ***Viatical settlement – A transaction whereby a written agreement is solicited, negotiated, offered, entered into, delivered or issued for delivery in this state, under which a viatical settlement provider acquires, through assignment, sale or transfer of a policy insuring the life of an individual who has a catastrophic or life-threatening illness or condition, by paying the owner or certificate holder compensation or anything of value that is less than the net death benefit of the policy.**
>
> ****Life settlement – A transaction whereby a written agreement is solicited, negotiated, offered, entered into, delivered, or issued for delivery in this state, under which a life settlement provider acquires through assignment, sale, or transfer of a policy insuring the life of an individual who does not have a catastrophic or life-threatening illness or condition, by paying the owner or certificate holder compensation or anything of value that is less than the net death benefit of the policy.**

El aceptar una liquidación tipo viáticos * o pago en vida ** podría afectar que usted pueda inscribirse en los programas de asistencia pública, tales como los de Asistencia Médica de Medicaid, Ayuda para Familias con Hijos Menores (AFDC), Ingreso Suplementario del Seguro Social (SSI) y otros programas de ayuda para la compra de medicamentos. Es posible que también tenga que pagar impuestos por el dinero que usted reciba por su seguro de vida.

Antes de firmar cualquier acuerdo tipo viáticos o pago en vida lo exhortamos que consulte con un abogado, contador, planeador de patrimonios, consejero económico, su aseguradora o agente de seguros, consejero (perito) en materia de impuestos o con (y con) una agencia (las agencies) de servicios sociales para que se informe cómo el recibo de dichos pagos podría afectar su capacidad, la de su familia y la de su cónyuge para recibir asistencia pública. Para más información en general respecto a los acuerdos tipo viáticos o pago en vida llame al Departamento de Seguros de Texas al 1-800-252-3439.

> ***Pago Tipo Viáticos – Una transacción en la cual por medio de un contrato por escrito a cumplir en este estado se solicita, negocia, ofrece, compromete, establece o expide, que bajo dicho contrato un proveedor de liquidación tipo viáticos adquiera, por medio de asignación, venta o transferencia, la póliza de seguro de vida de un individuo que padece de una enfermedad o padecimiento catastrófico o que amenaza la vida, al pagar al propietario o tenedor de la póliza una compensación o cualquier cosa de valor de menos cuantía que la suma neta del beneficio de muerte que estipula la póliza.**
>
> ****Pago en Vida – Una transacción en la cual por medio de un contrato por escrito a cumplir en este estado se solicita, negocia, ofrece, compromete, establece o expide, que bajo dicho contrato un proveedor de liquidación tipo pago en vida adquiera, por medio de asignación, venta o transferencia, la póliza de seguro de vida de un individuo que no padece de una enfermedad o padecimiento catastrófico o que amenaza la vida, al pagar al propietario o tenedor de la póliza una compensación o cualquier cosa de valor de menos cuantía que la suma neta del beneficio de muerte que estipula la póliza.**

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VIATICAL/LIFE SETTLEMENT APPLICATION

The information you provide in this application is used to determine whether you may be able to sell your life insurance policy. Failure to answer all of the questions or to provide the requested releases will delay the processing of your application. You must completed Sections 1, ll, and lll. If more space is needed, attach additional pages or write on the back of the application. Please answer as completely as possible or call 800-388-0103 if you have any questions. Thank you for submitting your application to ELA Settlement Services, LLC.

I. POLICY OWNER INFORMATION – TO BE COMPLETED BY THE POLICY OWNER (S)

The "Owner" is listed on your policy. It may or may not be the Insured.
INDIVIDUAL(S) OWNERS COMPLETE SECTION A BELOW.
TRUST, CORPORATION, OR OTHER ENTITY COMPLETE SECTION B BELOW.

SECTION A: Individual Owner(s)

Is there more than one owner? ☐ Yes ☐ No If multiple owners, provide this information ***on each.***

_____ _____
Owner Name: First Middle Last

_____ _____
Resident Address (not P.O. Box) Apt #

_____
City State Zip

In what other State do you have residence? _____
Phone:
Home: _____ Office: _____

Social Security #: ____ / _____ / _____

Are you the original policy owner? ☐ Yes ☐ No

Your relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Is there any court order requiring you to keep this Policy in force for the benefit of another person or Entity (e.g. divorce decree)?
☐ Yes ☐ No If yes, explain: _____

_____

_____

SECTION B. Trusts, Corporations, Partnerships or other Entities

Entity's Full Legal Name:

_____

Entity's Address:

_____

_____

_____
City State Zip

Contact Person. (If trust, Trustee's Name)

_____
First Middle Last

_____
First Middle Last

_____ _____
State of Incorporation (or other formation) If trust, state where Trust formed — Federal Tax ID Number

II. INSURED INFORMATION – TO BE COMPLETED BY THE INSURED (S)

The "Insured" is the person whose life is insured by the policy.
If the policy is a joint survivorship, complete for each insured.

SECTION A: General Information

Insured Name: First Middle Last

Resident Address (not P.O. Box) Apt. #

City State Zip

Home: _____ Office: _____

Insured's Date of Birth: _____/__/_____ Social Security Number: _____/___/_____

☐ Male ☐ Female

☐ Single ☐ Widowed

☐ Married ☐ Separated

☐ Divorced ☐ Registered Domestic Partner

Who is your Primary Care Doctor?

Doctor's Name: _____

Clinic: _____

Address: _____

_____

_____

Telephone: _____ How long: _____

Have you received any home health care services in the past five years? If yes::

Name of Provider: _____

Address: _____

_____

Dates: _____

Type of Care Provided: _____

_____

Have you been confined in a hospital, nursing home, or other medical facility during the past five years? If yes:

Name of Facility: _____

Address: _____

_____

Dates: _____

Reason for Confinement: _____

_____

Other Physicians within five years:

1.

Name:	
Clinic:	
Address:	
Telephone:	
Specialty:	

2.

Name:	
Clinic:	
Address:	
Telephone:	
Specialty:	

3.

Name:	
Clinic:	
Address:	
Telephone:	
Specialty:	

If Additional space is needed, use the back of this page.

SECTION B. INSURED'S MEDICAL CONDITIONS

Indicate whether you have experienced or been treated for any of the following conditions in the past five years. If yes, indicate the disorder, the treatment, and the year(s) of treatment. (For example: heart attack 2/2001, etc.) Also indicate any medication you are currently taking for the condition.

☐ Heart condition, high cholesterol, heart attack, angioplasty, A fib
Describe: _____
Medication: _____

☐ High blood pressure, stroke or disorder of blood vessels
Describe: _____
Medication: _____

☐ Cancer
Describe: _____
Medication: _____

☐ Lung or respiratory condition, COPD, shortness of breath
Describe: _____
Medication: _____

☐ Diabetes (Indicate if taking insulin)
Describe: _____
Medication: _____

☐ Stomach, intestines, gallbladder, or liver disorder
Describe: _____
Medication: _____

☐ Kidney, bladder, prostrate or reproductive organ disorder
Describe: _____
Medication: _____

☐ Skin, lymph glands, muscles or joint disorder
Describe: _____
Medication: _____

☐ Brain disorder, Alzheimer's, Stroke, Parkinson's disease TIA's
Describe: _____
Medication: _____

☐ Dependency on alcohol or drugs (non-therapeutic)
Describe: _____
Medication: _____

☐ Other
Describe: _____
Medication: _____

III. POLICY INFORMATION – TO BE COMPLETED BY THE POLICY OWNER (S)

SECTION A: General Policy Information

Insurance Company Name: _____

Policy Number: _____

Face Amount (Amount of Life Insurance): _____

Effective Date of Policy: _____
Month / Day / Year

Policy Type: _____

SECTION B: Premium Information

How often are premiums due? ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

Premium Amount due? _____

When is the next premium due? _____
Month / Day / Year

SECTION C: Loans & Collateral Assignment

Have you taken any loans against your policy? ☐ No ☐ Yes

If yes, what is the amount of the existing loan? $ _____

☐ Don't know

Have you assigned your policy to anyone (e.g. a bank) as collateral for a loan?

☐ No ☐ Yes

If yes, how much is the loan? $ _____

SECTION D: Lapsed Policy / Bankruptcy

Has this policy ever lapsed? ☐ No ☐ Yes

If yes, the effective date of the reinstatement? _____
Month / Day / Year

Have you filed for bankruptcy since the policy's effective date?

☐ No ☐ Yes

If yes, when was it discharged? _____
Month / Day / Year

(If you decide to sell your policy, a copy of the decree will be required)

I/We agree that all of the information provided in this application is material to a Viatical Settlement Provider or Life Settlement Provider decision whether to buy the policy (ies). I/We represent that all of the information is true and correct to the best of my/our knowledge. I/We agree that this application will become a part of my/our viatical/life settlement contract.

NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an Insurance company, a viatical provider, or a life settlement provider for the purpose of defrauding the company. Penalties may include imprisonment, fines, and civil damages. ELA Settlement Services, LLC will report cases of Suspected fraud to the appropriate authorities.

Witness Signature	OWNER'S Signature
Print Witness's Name	Date Signed
Witness Signature	INSURED'S Signature
Print Witness's Name	Date Signed
Witness Signature	SECOND OWNER'S Signature (if applicable)
Print Witness's Name	Date Signed
Witness Signature	SECOND INSURED'S Signature (if applicable)
Print Witness' Name	Date Signed

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Important Information You Need toKnow Before Entering into a Viatical or Life Settlement

What are Viatical settlements?

A viatical settlement is the sale of a life insurance policy or certificate (hereafter referred to as policy) issued on the life of a person, who has a catastrophic or life-threatening illness or condition that is likely to result in death within 24 months, for a dollar amount that is less than the policy's face value. The person with the catastrophic or life-threatening illness or condition who is insured under the policy is called a viator. This person may or may not be the owner of the policy. Only the owner has the right to sell the policy. The entity that buys the policy is called a viatical settlement provider (hereafter referred to as provider). The provider must have a registration from the Texas Department of Insurance. The provider representative and broker must also have a registration with the Texas Department of Insurance.

A viatical settlement offers the opportunity to receive a portion of your policy's death benefit while you are still alive. If the viator is the owner of the policy, the proceeds from a viatical settlement may be exempt from federal income tax under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Some states also exempt state income tax. Professional guidance should be obtained regarding federal and state tax consequences.

What are life settlements?

A life settlement is the sale of a life insurance policy or certificate (hereafter referred to as policy) issued on the life of a person, who **does not** have a catastrophic or life-threatening illness or condition that is likely to result in death within 24 months, for a dollar amount that is less than the policy's face value. The person may or may not be the owner of the policy. Only the owner of the policy has the right to sell the policy. The entity that buys the policy is called a life settlement provider (hereafter referred to as provider). The provider must have a registration from the Texas Department of Insurance. The provider respresentative and broker must also have a registration with the Texas Department of Insurance.

How do viatical/life settlements work?

Most providers, provider representatives, or brokers will ask you to complete an application, policy release and medical release forms so they can gather information from your life insurance company and your doctors. All information gathered must be kept confidential and cannot be given to anyone without your written approval. If you qualify, the provider will make you an offer for your policy. The amount offered for your policy will be based on facts such as; how long you are expected to live, the amount you pay for premiums, the rating of your insurance company, and your policy's provisions, (e.g., a waiver of premium). If you accept the offer, you will be asked to sign a viatical or life settlement contract.

Is there a difference between a broker and a provider representative?

Yes. Although both a broker and a provider representative will help you with the sale of your policy, there are important differences between them. A broker works for you and checks with several providers to find the best offer for you. A provider representative works for a provider and will only check with the provider he or she works with to get you their offer. If you use someone to help with the sale of your policy, you may want to ask whether they are a broker or a provider representative.

Is the provider, provider representative, or broker required to keep my information confidential?

Yes, any financial, medical or personal information obtained by a provider, provider representative, or broker about you, including your family members, spouse, or significant other, may not be shared with anyone unless you have given written approval that the information may be shared. Any written approval for sharing of this information must show who may receive the information and why it will be released.

If I enter into a viatical or life settlement contract, when will I get my money and from whom?
It depends on how the provider runs its business. Most providers use an escrow agent or trustee to handle the money that will be paid to you. If an escrow agent or trustee is used, the escrow agent or trustee will send you the money within three business days of the date the insurance company confirms to the provider that the transfer of ownership has been completed. If an escrow agent or trustee is not used, the provider will send you the money within three business days from the date you signed both the contract and the papers needed to transfer or assign your policy to them.

Do I have to sell all of my policy?
You can sell all of your policy or, if your insurance policy has provisions for splitting or otherwise dividing the policy, you may sell only a portion of the policy.

What if I change my mind?
If you change your mind about selling your policy, you can cancel the viatical or life settlement contract at any time up to the 15th day after you receive the money from the provider. To cancel the viatical or life settlement contract, you will have to return any money the provider paid to you for the purchase of your policy along with any premiums the provider paid to keep the policy in force. If you change your mind, remember to arrange with the provider to have the insurance company transfer the ownership of the policy back to you.

What if I die shortly after selling my policy?
If you die at any time up to the 15th day after you receive the money from the provider, the viatical or life settlement contract will automatically cancel. The provider will pay the owner of your policy or beneficiaries designated by the owner in the viatical or life settlement contract any proceeds it receives from your policy minus any money it already paid for the purchase of your policy and any premiums it paid to the insurance company to keep your policy current. The insurance company or the provider should refund any unearned premiums paid.

What happens after I get my money?
After the viatical or life settlement provider has paid the owner for the sale of the policy, they may begin calling to check on the heath status of the Viator or Life Settlor.

What if I don't want to be contacted about my health status?
If you do not want to be contacted about your health status, you may appoint an adult person or persons to be contacted on your behalf. That person must be in regular contact with you and you must give the provider their name, address and phone number. Once you give the provider this information, they may not contact you unless they have tried and have not been able to reach the contact person for more than 30 days. You can change your contact person at any time by sending a written notice to the provider.

How will I know who will be calling me or my contact person about my health status?
The provider must give you the name, address and phone number of the person who will be contacting you or your contact person(s) about your health status.

How often can they call?
If your life expectancy is expected to end in one year or less, contacts to check on your health status are limited to once every 30 days. If you are expected to live for more than one year, contact is limited to once every three months.

Will the provider be calling my doctor to check my health status?
Some providers will use your signed medical release form to check with your doctor for updates on your health status. This form tells your doctor that you want him/her to give your medical information to the provider, their broker, or provider representative. If you decide you do not want the provider to contact your doctor, you have the right to withdraw your medical consent in accordance with law.

Does anyone make money or commissions from the sale of my policy?
You have the right to ask for and receive the names of all the people who have or will receive some type of payment from the sale of your policy, along with the amount and terms of the payment. You may ask for this information at any time.

How will I know if my policy includes extra coverage like accidental death, future increases in the death benefit, or covers other family members? Do these affect my settlement?
Some policies contain extra coverage. You may want to contact your insurance company or agent to see if your policy contains a provision or rider providing extra coverage. If your policy includes a benefit for accidental death, the additional death benefit may not be included as part of your settlement. The additional death benefit will remain payable to your beneficiaries or your estate. If your policy provides future increases in the death benefit, you may want to ask how much the provider is paying you for the purchase of this benefit. If your policy is a joint policy, or provides coverage on the lives of other family members or anyone other than yourself, there may be a possible loss of coverage.

Are there other options available besides selling my policy?
Your insurance company may offer options, such as accelerated death benefits, loans and surrender of the policy for its cash value. Before entering into a settlement, you should contact your insurance company or agent to see what options are available.

What other facts should I know about a viatical or life settlement contract?
Some things that may be affected if you enter a settlement are:

- Loss of life insurance coverage on your spouse or other family members if the policy (or any riders attached to it) covers their lives;
- Amount of premium you pay if only a portion of the policy is sold;
- Policy cash values or dividends if provided for in the policy;
- Loss of other rights or benefits, including conversion rights and waiver of premium benefits that may exist under your policy;
- Possible tax consequences;
- Ability to receive supplemental social security income, public assistance and public medical services including Medicaid.
- Money you receive for your viatical or life settlement could be taken from you by creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.

Because of the above, you should contact an attorney, accountant, estate planner, financial planning advisor, tax advisor, social services agency, your insurance company, or agent, as applicable to find out what effect selling your policy will have on you.

What if I have a complaint?
You may file a complaint with the Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, P.O. Box 149091, Austin, TX 78714-9091, or by calling the Consumer Help Line between 8 a.m. and 5 p.m., central time, Monday-Friday at 1-800-252-3439; or by faxing a complaint to TDI at 1-512-475-1771; or by completing a complaint on-line at www.tdi.state.tx.us; or by mailing a complaint to consumer.protection@tdi.state.tx.us.

ELA SETTLEMENT SERVICES, LLC
1435 Morris Avenue
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800-388-0103 908-851-0770 908-810-4159

Acknowledgement Form for Viatical/Life Settlement Application

THE STATE OF _____ COUNTY OF _____

KNOW ALL MEN BY THESE PRESENT THAT _____
Name of Viator/Life Settlor

OR _____ does acknowledge that, to the best of their
Name of Policy Owner, if different from theViator/Life Settlor

knowledge, the following are true representations:

- The Viator/Life Settlor (has/does not have) a catastrophic or life-threatening illness or condition that is likely to result in death within 24 hours.
- A copy of the required written disclosures have been received and read by the Viator/Life Settlor and the Policy Owner.
- All of the documents (applications, medical release forms, etc.) used to effect the Viatical/Life Settlement have been received and read by the Viator/Life Settlor and the Policy Owner.
- The Viatical/Life Settlement contract is being entered into knowingly and voluntarily.

Witness my hand this _____ day of _____.

_____ _____
Signature of Viator/Life Settlor Signature of Policy Owner, if different from Viator/Life Settlor

_____ _____
Printed Name of Viator/Life Settlor Printed Name of Policy Owner

_____ _____
Address Address

_____ _____
City State Zip City State Zip

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800-388-0103 908-851-0770 908-810-4159

THE STATE OF _____ COUNTY OF _____

Before me, _____ on this day personally appeared
Print Name of Notary

_____ or _____
Print Name of Viator/Life Settlor Print Name of the Policy Owner, if different from the Viator/Life Settlor

known to me to be the person(s) whose name (s) is subscribed to the foregoing instrument and acknowledged to me that the named person(s) executed the same for the purposes and considerations therein expressed, in the capacities therein stated and as the act and deed of the said Viator/Life Settlor and Policy Owner.

Given under my hand and seal of this office _____ day of, _____

Notary Seal

_____
Notary Public Signature

Notary Public, State of: _____

My Commission Expires: _____

ELA SETTLEMENT SERVICES, LLC
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Policy Information Release

Policy Owner: _____

Social Security #: _____

Insurance Co.: _____

Policy #: _____

I authorize and instruct the life insurance company listed above to release all information about the above-referenced policy directly to ELA Settlement Services, LLC. This Authorization includes, but is not limited to, the release of the following to ELA Settlement Services, LLC upon their request:

- A complete copy of the life insurance policy, including the application for Insurance, or, if a group policy, the master policy and employee certificate.
- All forms requested by ELA Settlement Services, LLC including change of ownership forms, change of beneficiary forms and collateral and absolute assignment forms.
- A fully-completed Verification of Coverage form.
- Policy Illustrations
- A copy of the Annual Statements: and
- Premium information

This release is being provided for the purpose of a Viatical or Life Settlement. I further instruct the Life Insurance Company listed above not to disclose my request for this information to any agent or other person or entity without my prior approval. This release will remain valid for one year from the date it is signed. This release may be withdrawn at any time pursuant to applicable law.

A COPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL.

_____ _____
Owner Signature Date

ELA SETTLEMENT SERVICES, LLC
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The following registered entities may be considered by ELA Settlement Services, LLC for submission of application for viatical or life Settlement for an owner or insured who resides in Texas. If there are any changes to this form, we will notify Texas Department of Insurance.

ABACUS SETTLEMENTS, LLC

COVENTRY FIRST, LLC

FAIRMARKET LIFE SETTLEMENT CORP.

HABERSHAM FUNDING, LLC

LEGACY BENEFITS CORPORATION D/B/A LEGACY SETTLEMENTS CORPORATION

LIFE EQUITY LLC

LIFE SETTLEMENT CORPORATION D/B/A PEACHTREE LIFE SETTLEMENTS

MAPLE LIFE FINANCIAL, INC

PORTSMOUTH SETTLEMENT COMPANY 1, INC

PROGRESSIVE CAPITAL SOLUTIONS, LLC D/B/A PROGRESSIVE TRANSACTION, LLC

Q CAPITAL STRATEGIES LLC

SEVEN HILLS SETTLEMENT, LLC

VESPERS, LLC D/B/A VESPERS FUNDING, LLC D/B/A VESPERS FINANCIAL GROUP LLC

VIASOURCE FUNDING GROUP, LLC

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The undersigned insured(s) (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:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any 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 Authorized 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 Authorized HCP to disclose my PHI under this authorization to ELA Settlement Services, LLC, EMSI Operating, LP (D/B/A Examination Management Services, Inc) and 21st Services (each an "Authorized Recipient"). I understand that my PHI may be secured by EMSI Operating, LP (D/B/A Examination Management Services, Inc) (an authorized discloser) and may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website.

3. Description of 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, including but not limited to information/records as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including psychiatric conditions, drug or alcohol abuse, of or relating to the Insured(s), whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization allows for the disclosure, inspection and copying of any and all medical 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(s), along with any and all medical charts, clinical or doctor's notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control. I understand that this Authorization may be used to track the on-going health status of the Insured(s).

4. I understand that viatical settlement providers and life settlement providers, their medical underwriter, contingency reinsures and any other entity which requires or is compelled by law to receive such PHI to complete a viatical settlement or life settlement contract (each "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose of pursuing and / or completing the sale of life insurance policy which I am the insured under this authorization. I understand that my PHI may be secured by a registered broker, provider or provider representative (listed below) and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy or facsimile of this authorization shall be valid as the original.

Registered Broker, Provider or Provider Representative:

5. Expiration of Authorization: This authorization shall remain valid for the life of the viator or life settlor or until the policy lapses without the possibility of reinstatement, whichever is earlier, 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.

6. Right to Revoke Authorization: I acknowledge and understand that I may withdraw this authorization any time with respect to any Authorized HCP and ELA Settlement Services, LLC by notifying such Authorized HCP and ELA Settlement Services, LLC 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 Authorized HCP and ELA Settlement Services, LLC; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP or ELA Settlement Services, LLC has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

7. 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 specifically authorize and request each authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of 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 Authorized 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.

The undersigned Insured(s), understand that all medical information will be kept strictly confidential and will not be released to the Medical Information Bureau or to any other party without consent. I have the right to withdraw my consent pursuant to applicable law.

This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below 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.

INSURED

AGREED and ACCEPTED this _____ day of _____ (Month) , _____ (Year)

Insured: _____ (Signature) _____ (Printed Name)

SECOND INSURED (if applicable) NA

AGREED and ACCEPTED this _____ day of _____ (Month) , _____ (Year)

Second Insured: _____ (Signature) _____ (Printed Name)

(1) Protected health insurance ("PHI") is health information that is created or received by health care provider, health plan or health care clearinghouse which relates to 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past or future payment for the provision of health care to an individual. To be protected, the information must be such that it determines the individual or provides a reasonable basis to believe tha the information can identify the individual 45 C.F.R. 164.508

(2) These laws apply to health plans, health care providers, and health care clearinghouses.