PAUL H. NAGELBERG AGENCY
D/B/A ELA SETTLEMENT SERVICES, LLC
1435 Morris Ave., P.O. Box 3137, Union, NJ 07083
Telephone: 1-800-388-0103 Fax: 908-810-4159

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

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 # _____
Date Last Seen: _____

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 application 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 application 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 application 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 application.

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.

Owner's signature _____

Typed or printed name _____ Date _____

Witness signature _____

Printed Name _____ Date _____

MEDICAL INFORMATION FOR THE INSURED

Insured's Name _____ Insured's Phone Number: _____

1. In your own words, please provide a status of the present health condition of the insured along with any details of any medical impairments. Please also specify all medication currently being taken including the frequency and dosage of such medication. (please use continuation sheet if necessary and complete a second sheet of this page for the second insured - if applicable).

I certify that the above is a full and accurate description of my current health situation and that by signing below I indicate my authorization for a telephone medical interview as part of this underwriting process to sell this policy.

Insured Name _____ Date _____

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REQUIRED DISCLOSURES TO INSURED

IMPORTANT- READ THIS DISCLOSURE FORM DOCUMENT BEFORE SIGNING IT. THIS DISCLOSURE SHALL BE SIGNED BY THE INSURED NO LATER THAN THE DATE THE LIFE SETTLEMENT CONTRACT IS SIGNED BY ALL PARTIES.

You should carefully read the following information and seek financial, insurance or other advice where appropriate.

1. You, the insured, may be contacted by either the life settlement provider or its authorized representative for the purpose of determining your health status or to verify your address. You may not be contacted more often than once every three months if you have a life expectancy of more than one year, and no more than once per month if you have a life expectancy of one year or less.

2. A change of ownership of the policy that is the subject of this life settlement contract could in the future limit your ability to purchase future insurance on your life because there is a limit to how much coverage insurers will issue on one life.

3. All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about you, the insured, including your identity or the identity of your family members, your spouse or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and 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 information every two years.

4. ***No medical, financial or other personal information may be disclosed without your written consent.***

ACKNOWLDEGEMENT OF THIS DOCUMENT DOES NOT CONSTITUTE CONSENT TO DISCLOSURE OF YOUR MEDICAL, FINANCIAL OR OTHER PERSONAL INFORMATION.

INSURED'S ACKNOWLEDGMENT: I have read and received a copy of the Required Disclosures to Insured and acknowledge with my signature below.

_____ _____

Insured's Signature **Dated**

_____

Insured's Printed Name

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Section 7810 of the New York Insurance Code requires that with respect to all life settlement transactions governed by New York law, the policy owner and the insured must provide written consent to the disclosure of nonpublic personal information, including financial information and medication information, prior to the submission of that information by a life settlement broker to a life settlement provider or by the life settlement provider to its financing entity.

The undersigned is the owner of, and/or named insured under, one or more life insurance policies identified below. In order to effect a life settlement contract between the owner and a life settlement provider, or to effectuate the sale or transfer of a life settlement contract or a settled policy, or interest therein, the undersigned each hereby consents to and executes this Authorization to Release Confidential Information ("Authorization") as prior written consent to the disclosure and release of certain confidential information, including the identity of owner and/or insured, identifiable information and such financial and medical information as may be necessary to the authorized recipients specified herein.

Information Authorized to be Released: Any information (1) concerning or related to the identity of the owner of, or the named insured under, the life insurance policies identified below, (2) that there is a reasonable basis to believe could be used to identify the insured or owner, and (3) concerning or related to the owner's or insured's financial or medical information may be released to the Authorized Recipients (as defined below). Such information may include (but is not limited to): names, addresses, telephone numbers, email address, personal identifying information, including social security number, information contained in the Application for the Policy and Life Settlement, tax records, medical records and information, information held by the Insurer regarding me or the Policy, credit information, financial information, and other non-public personal information of or related to the insured or the owner, or representative thereof; and the related insurance policy number(s).

Authorized Recipients of Information: Information authorized to be released hereunder may be released to and received by (1) any licensed life settlement broker; (2) any licensed life settlement provider (a "life settlement provider") and/or its authorized representative; (3) any life settlement intermediary (4) any person who may seek to purchase from such life settlement provider any life insurance policy insuring the below identified insured's life or other insurance product owned by the below identified owner; (5) any financing entity of a life settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers; (6) any service provider, including, but not limited to, any life expectancy underwriter, escrow agent or trustee, tracking and monitoring, post-purchase policy servicer; (7) any life insurance or annuity company that has issued a life insurance policy insuring the below identified insured's life; (8) any other entity(ies) expressly named herein as: and (9) any of the respective affiliates, directors, officers, employees, agents, representatives, independent contractors, accountants, actuaries, attorneys and other representatives and advisors, and successors and assigns of any of the persons or entities covered in the immediately foregoing clauses (1) through (8), inclusive (each, an "Authorized Recipient"). Each Authorized Recipient in receipt of information authorized to be released by this Authorization may share any such information with any other Authorized Recipient as if such other Authorized Recipient had received such information directly from the undersigned.

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The undersigned each certify that this Authorization has been made freely, voluntarily and without coercion and that the information shown below is accurate and complete to the best of the undersigned's knowledge. The undersigned understands that any revocation of this Authorization will not apply to information that has already been released in response to this Authorization. Redisclosure of the undersigned's information by those receiving the above authorized information may be accomplished without the undersigned's further written authorization and may no longer be protected. The undersigned releases any Authorized Recipient from any and all liability for actual or alleged damages to the undersigned as a result of good faith compliance with this Authorization. This Authorization is valid for the duration of the life insurance policy(ies) specified below, provided that this Authorization shall be of no force or further effect if a life settlement contract is not effected, or if rescinded. The undersigned each consent to the disclosure and release of his/her confidential information and acknowledges receipt of a copy of this Authorization.

A copy of this Authorization may be accepted as an original. This Authorization may be sent via facsimile transmission.

Life Insurance Policy Information

Insurance Company — Policy Number

Insurance Company — Policy Number

Insurance Company — Policy Number

Policy Owner Information

Policy Owner Name

Signer's Printed Name | Signature | Title (if applicable) | Date

Street Address

City | State | Zip Code

Witness Printed Name | Witness Signature | Date

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Insured Information

Insured Printed Name	Insured Signature	Date

Street Address

City	State	Zip Code

Witness Printed Name	Witness Signature	Date

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Fax: 908-810-4159/Phone: 1-800-388-0103/908-851-0770

NOTICE: THE LIFE SETTLEMENT PROVIDER OR BROKER SHALL DELIVER THIS CONSUMER INFORMATION BOOKLET TO EVERY APPLICANT BEFORE AN APPLICATION FOR A LIFE SETTLEMENT CONTRACT IS COMPLETEDAND SIGNED BY YOU.

Life Settlements – What You Should Know Before Selling Your Life Insurance Policy

What is a Life Settlement?

A life settlement is the sale of a life insurance policy to a third party called a life settlement provider. The owner of the life insurance policy sells the policy to the life settlement provider and receives an immediate payment in return.

The life settlement provider becomes the new owner of the life insurance policy, pays any future premiums and receives the death benefit when the person whose life is insured under the policy (the insured) dies.

The New York State Insurance Department wants you to have the facts before you sell your life insurance policy. This booklet provides some of that information, but it is only a starting point. **Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.**

Consider Your Options

If you are planning to sell your policy to get cash to pay expenses, there may be other options available under your policy that may allow you to keep your policy in force for your beneficiaries.

Ask your insurance agent or insurance company if your life insurance policy has any cash value. Generally, life insurance policies allow you to take a policy loan up to the amount of the cash value. You may also be able to take out some of the cash value to meet your immediate needs. You should seek the advice of your insurance agent or other professional before using the cash value of your policy.

Find out if your policy allows you to reduce the amount of the death benefit in order to lower the amount of premium you are required to pay. If you are planning to sell your policy because the premiums have gotten too high, this may provide a way to maintain some of the death benefit in force.

Find out if your policy has an accelerated death benefit. If the insured under the policy is terminally or chronically ill, you may be able to accelerate some or all of the death benefit while the insured is still alive.

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Other Important Information

- Comparison shop. Get quotes from several life settlement providers to make sure you have a competitive offer.
- If you use a life settlement broker, the broker represents exclusively you and has the duty to act in your best interests and according to your instructions.
- If you use a life settlement broker, he or she is required to disclose the amount of compensation to be paid to him or her by no later than the date the life settlement contract is signed.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax-free.
- It is important to know that the proceeds you receive from a life settlement may be accessible by your creditors.
- Find out if you will lose any public assistance benefits, such as supplementary social security benefits, food stamps or Medicaid, or other governmental benefits or entitlements if you receive proceeds from a life settlement transaction.
- The life settlement provider or its authorized representative may contact the insured for the purpose of determining his/her health status. The insured may not be contacted more often than 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.
- The insured's medical, financial or other personal information may be disclosed to certain other parties if the insured has provided written consent for these disclosures.
- After a life settlement provider buys your policy, the provider may resell the policy to other parties.
- You have the right to change your mind about the life settlement transaction AFTER you receive the proceeds of the life settlement. You have the right to rescind (cancel) the life settlement contract from the time the contract is signed until fifteen days after you receive the proceeds.
- If you asked to or you plan to buy a new life insurance policy with a primary purpose of selling it to a third party, then this may be a stranger-originated life insurance (STOLI) transaction that is prohibited by the New York Insurance Law.

Questions to Ask Your Professional Financial Advisor, Insurance Agent, Employer or other Professional Advisor

- If I sell my policy, will I still need life insurance protection?
- If I sell my policy, will the insured under the policy be able to buy additional life insurance on his/her own life?

- If I have a group life insurance certificate under an employer or other group life insurance policy, does the policy permit me to sell it?

If you have questions about selling a life insurance policy, life settlements generally or a life settlement provider, life settlement broker, or life settlement intermediary, you may contact the New York State Insurance Department. Visit the Department's website at http://www.ins.state.ny.us.

I/We, applicant(s), acknowledge receipt of this consumer information booklet from the life settlement provider or life settlement broker before the application for the life settlement contract is completed.

Policy Owner 1

_____ _____
Signature of Policy Owner Dated

_____
Printed Name of Policy Owner

Policy Owner 2

_____ _____
Signature of Second Policy Owner, if applicable Dated

_____
Printed Name of Second Policy Owner

Insured

_____ _____
Signature of Insured Dated

_____
Printed Name of Insured

Insured 2

_____ _____
Signature of Second Insured, if applicable Dated

_____
Printed Name of Second Insured

ela SETTLEMENT SERVICES

1435 Morris Avenue
P.O. Box 3137,
Union, NJ 07083-1937
Phone: 800-388-0103
Fax: 908-810-4159

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**, a Life Settlement Wholesaler, any of the following information if requested by them.

- **A fully completed Verification of Coverage Form (VOC)**
- **A complete copy of the above mentioned policy**
- **Policy illustrations**
- **Premium and Annual Statement Information**

I respectfully request that you reply immediately to any request for information or letters required by **ELA Settlement Services** 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 _____

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 settlement agency of record is ELA Settlement Services, LLC.

_____ _____

Signature of Owner Date

_____

Address

_____ _____

Witness Date

_____

Printed Name of Witness

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

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

BROKER CHECKLIST FOR APPLICATION 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 Application to be processed.

❑ Application 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 60 days of application. If not in your possession, ELA Settlement Services will order.

❑ 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. ID must be current, not expired.

❑ Complete copy of the insurance policy or Spec. page. If this is not available immediately, please advise in your cover letter and forward to ELASS as soon as possible.

❑ Current in-force illustration from the insurance company with application showing the following (if you are not the Agent of Record, ELASS will order):

❑ Universal Life – minimum premium payment to policy maturity.

❑ Term – proposed conversion illustration to Universal showing a minimum payment to policy maturity.

❑ Whole Life – run a natural vanish premium illustration to policy maturity.

❑ Owner and Beneficiary (ies) of the policy.

If owner/beneficiary is a trust, we need:

❑ Copy of trust and Tax ID#

❑ One Trustee must sign the policy information release form

If owner/beneficiary is a corporation, we need:

❑ Complete name and address of corporation

❑ Two officers must sign the policy information release form

FOR AGENTS ONLY: Broker_____

Address:_____

Phone:_____ Fax:_____

E-Mail:_____

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

ELA Settlement Services, 1435 Morris Ave., P.O. Box 3137, Union, NJ 07083

ELA SETTLEMENT SERVICES

The attached four pages is the NAIC approved request form for Verification of Coverage in states which regulate Life Settlements. We also use this form for unregulated states.

Please have the owner/s of the policy sign and date at the bottom of Page 1. We need the Producer or the MGA to complete the first column next to the questions outlined on Pages 1, 2 and 3 to the best of their ability.

Please transmit back to ELA Settlement Services along with the completed and signed ELASS Application.

1435 Morris Avenue • P.O. Box 3137 • Union, New Jersey 07083-1937 • (908) 851-0770 • (800) 368-0103 • Fax (908) 810-4159

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO:_____ **NAIC #**_____
Name of Insurance Company

POLICY NUMBER:_____

SUBMITTED FROM:_____
Name of Viatical Settlement Broker/Provider

ADDRESS:_____

TELEPHONE NUMBER:_____

CONTACT:_____ **TITLE:**_____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or Social Security number	*	
Insured's name	*	
Insured's date of birth	*	
Second Insured's name (if applicable)	*	
Second Insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

_____ _____
Signature of policy owner Date signed

IS THE POLICY IN FORCE? _____YES _____NO

IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

***____TERM ____WHOLE LIFE ____UNIVERSAL LIFE ____VARIABLE LIFE**

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy	*	
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?	*	
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Policy values as of (insert date)	*	
Current face amount of policy	*	
Amount of accumulated dividends	*	
Current face amount of riders	*	
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans	*	
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?	*	

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)	*	
Date of last cost of insurance deduction	*	

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

_____ _____

Signature Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____ (date).

Insurance company: _____ NAIC # _____

Printed name: _____ Title: _____

Telephone number: _____ Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____ Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____ Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- o Absolute Assignment/Change of Ownership/Viatical Assignment
- o Change of Beneficiary
- o Release of Irrevocable Beneficiary (if applicable)
- o Waiver of Premium Claim Form
- o Disability Waiver of Premium Approval Letter
- o Release of Assignment
- o Change of Death Benefit Option Form (if UL)
- o Allocation Change Form (if Variable)
- o Annual Report
- o Current In Force Illustration