

# Solutions for Life

## APPLICATION

### Personal Information (Please Print or Type):

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Life Insurance Information (Current):

Owner of Policy: \_\_\_\_\_

Trustee: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Life Insurance Co: \_\_\_\_\_

Policy #: \_\_\_\_\_ Benefit Amount: \_\_\_\_\_

Issue Date: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Policy Type: Individual \_\_\_\_\_ Group \_\_\_\_\_ Other \_\_\_\_\_ (Please specify)

Has policy ever lapsed?  Yes  No

Please list your beneficiaries:

<u>Name:</u>	<u>Relationship:</u>
_____	_____
_____	_____

**Medical Information:**

Please describe your current medical condition(s), if any. Also, please provide the names of all medications you are currently taking.

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Please provide the name of your physician(s) and/or hospital so that we may contact them to obtain your medical records. A separate sheet is provided for additional physician information.

**Physician:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Hospital:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Additional Information (comments that may assist in determining your eligibility):

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**Additional Physician #1**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason seen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Physician #2**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason seen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Physician #3**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason seen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Notice of Disclosure of Information

1. Selling your life insurance policy is an important decision. You may have certain tax consequences resulting from the sale of your policy and should request assistance from a personal tax advisor.
2. The sale of your insurance policy may affect your right to receive government benefits or entitlements.
3. Settlement Broker may be compensated. Our net amount equals the lesser of a percent of the face amount of the Life Insurance Policy or a percent of the client's net settlement, but not to exceed six percent of the face amount of the Life Insurance Policy.
4. There may be possible alternatives to selling your life insurance. This may include the option of an Accelerated Death Benefit offered by your insurance company. You are advised to consult a financial advisor, certified public accountant or an attorney regarding those potential alternatives.
5. You will be informed, upon request, of the name, address, and phone number of the escrow agent that disburses your settlement proceeds. Further, you may inspect or receive copies of your escrow agreement(s) for your settlement from the escrow agent.
6. Once you have received your proceeds from the sale of your life insurance policy, you will have a fifteen (15) day period in which to rescind the transaction. This is your full and legal right. You are advised to refer to the purchasing contract supplied by the Provider/Purchaser Company of your life insurance policy regarding this matter.
7. Settlement proceeds could be subject to the claims of creditors.
8. Settlement Broker is not affiliated with any Provider/Purchasing Company or Insurer.
9. Settlement Broker represents the viator<sup>1</sup> and owes the viator a fiduciary duty to act according to the viator's instructions and in the best interest of the viator.

## Terms & Conditions

1. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison.
2. The applicant warrants and represents that all information contained in this application is true and correct to the best of his/her knowledge.

\_\_\_\_\_  
Signature of Insured/Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policy Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
<sup>1</sup> For purposes of this form, **Viator** means policy owner, insured, and/or applicant.

## Authorization To Release Medical Records

I hereby authorize any physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider (each, an "HCP") to provide Solutions for Life, Inc., and/or any of its affiliates, officers, directors, employees, agents, independent contractors, service providers or other authorized representatives (each, an "Authorized Recipient"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each HCP to release to the Authorized Recipient the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

This authorization shall apply to any and all of my health and medical data, information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. I understand that this authorization and all disclosures of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") made under this Authorization will be treated as confidential and will only be used by the Authorized Recipient in connection with the possible sale of a life insurance policy (Life Settlement). I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any HCP by notifying such HCP of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such HCP; provided, that, any revocation of this Authorization shall not apply to the extent that the HCP has taken action in reliance upon this Authorization prior to receiving written notice of my revocation.

I understand that this Authorization is not consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the HIPAA Privacy Regulations. I further understand that, as a result of this Authorization, any of my medical information disclosed by any HCP to the Authorized Recipient may be redisclosed by the Authorized Recipient and 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 and that all information contained in this Authorization is true and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request each HCP to rely upon a photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one (1) year following the date of my death.

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NAME OF INSURED

SIGNATURE

DATE

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DATE OF BIRTH

SOCIAL SECURITY NUMBER

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NAME OF SECOND INSURED (*If applicable*)

SIGNATURE

DATE

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DATE OF BIRTH

SOCIAL SECURITY NUMBER

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NAME OF OWNER (*If other than insured*)

SIGNATURE

DATE

**Authorization to Release Policy Information**

I hereby authorize \_\_\_\_\_, the issuer of that certain policy number \_\_\_\_\_, owned by \_\_\_\_\_, and insuring the life of \_\_\_\_\_, to release to **SOLUTIONS FOR LIFE**, or its Funding Sources, any information, including riders, policy values, in-force illustrations, amendments and/or a true copy concerning this Policy. A photocopy or facsimile of this authorization shall be considered as valid as the original. I understand that I may request a copy of this information.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

I acknowledge receipt of the Notice of Disclosure of Information.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Signature of Policy Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name of Policy Owner