



Life Settlement Services, LLC (“LSS”) will use the information you provide in this application to determine whether you may be able to sell your policy. Failure to answer all of the questions or to provide the LSS Medical and Policy Information releases may delay the processing of your application. Attach additional pages or write on the back of this application if you need more space to answer any questions. Please answer as completely as possible and call LSS at 800-592-2074 if you have any questions, we shall be happy to assist you. Thank you for submitting your application.

**LIFE INSURANCE POLICY INFORMATION—POLICY #1**

Insurance Company		Phone Number	Issue Date	Broker CRD #
Policy Number		Policy Type VL      UL      WL      TERM      SURV      Other		
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$	Current Cash Surrender Value \$	
Policy Owner		Owner's Social Security Number or Tax ID Number		
Owner's Permanent Address		Has the Policy Owner ever declared Bankruptcy? Yes      No		
City		State	Zip Code	
Beneficiary(ies)				

**LIFE INSURANCE POLICY INFORMATION—POLICY #2**

Insurance Company		Phone Number	Issue Date	Broker CRD #
Policy Number		Policy Type VL      UL      WL      TERM      SURV      Other		
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$	Current Cash Surrender Value \$	
Policy Owner		Owner's Social Security Number or Tax ID Number		
Owner's Permanent Address		Has the Policy Owner ever declared Bankruptcy? Yes      No		

City	State	Zip Code
Beneficiary(ies)		

**LIFE INSURANCE POLICY INFORMATION—POLICY #3**

Insurance Company	Phone Number	Issue Date	Broker CRD #
Policy Number	Policy Type VL          UL          WL          TERM          SURV          Other		
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$	Current Cash Surrender Value \$
Policy Owner	Owner's Social Security Number or Tax ID Number		
Owner's Permanent Address	Has the Policy Owner ever declared Bankruptcy? Yes          No		
City	State	Zip Code	
Beneficiary(ies)			

**INSURED #1 INFORMATION**

Insured's Name	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Insured's Address			Phone Number
City	State	Zip	

**PHYSICIAN INFORMATION**

Identify Primary Physician for insured. Please add pages and identify every other physician who has treated you during the past five years.

Doctor's Name:	Clinic or Hospital:		
Address:	Phone #:	Specialty:	
City:	State:	Zip Code:	
Date Last Seen:	Reason:		

Doctor's Name:		Clinic or Hospital:	
Address:		Phone #:	Specialty:
City:		State:	Zip Code:
Date Last Seen:	Reason:		

### INSURED #2 INFORMATION

Insured's Name	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Insured's Address			Phone Number
City	State	Zip	

### PHYSICIAN INFORMATION

Identify Primary Physician for insured. Please add pages and identify every other physician who has treated you during the past five years.

Doctor's Name:		Clinic or Hospital:	
Address:		Phone #:	Specialty:
City:		State:	Zip Code:
Date Last Seen:	Reason:		

Doctor's Name:		Clinic or Hospital:	
Address:		Phone #:	Specialty:
City:		State:	Zip Code:
Date Last Seen:	Reason:		

If available, please include the following:

**1. Two illustrations:**

- a. An illustration with a level death benefit running to maturity.
- b. An illustration with a level premium running to 10 years.

**APPLICATION AUTHORIZATION**

Notice: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company or a life settlement company for the purpose of defrauding the company. Penalties may include imprisonment, fines and civil damage. LSS will report cases of suspected fraud to the appropriate authorities.

**Policy #1 (Signatures MUST be Witnessed)**

_____ Owner's Signatures	_____ Date	_____ Second Owner's Signature	_____ Date
_____ Printed Name		_____ Printed Name	
_____ Insured's Signature	_____ Date	_____ Second Insured's Signature	_____ Date
_____ Printed Name		_____ Printed Name	
_____ Witness Name	_____ Date	_____ Witness Name	_____ Date

**Policy #2 (Signatures MUST be Witnessed)**

_____ Owner's Signatures	_____ Date	_____ Second Owner's Signature	_____ Date
_____ Printed Name		_____ Printed Name	
_____ Insured's Signature	_____ Date	_____ Second Insured's Signature	_____ Date
_____ Printed Name		_____ Printed Name	
_____ Witness Name	_____ Date	_____ Witness Name	_____ Date

**Policy #3 (Signatures MUST be Witnessed)**

\_\_\_\_\_  
Owner's Signatures      Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Insured's Signature                      Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness Name                              Date

\_\_\_\_\_  
Second Owner's Signature              Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Second Insured's Signature              Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness Name                              Date