VIATICAL SETTLEMENT APPLICATION

The responses you provide on this application will help determine whether you are eligible for a viatical settlement. This application should be completed by the insured, even if the insured is not the owner of the policy. WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

1. PERSONAL INFORMATION

a) Name:____

b) Home Phone:____________________________ Work Phone: _________________________

c) Cell Phone:______________________

d) Home Address:____

City:____State:________________Zip:_________________

e) Date of Birth:_____________________Place of Birth:_______________________________

f) Social Security Number:__________________________________ Sex: Male/Female (Circle)

g) Martial Status: Married / Single / Divorced / Separated / Widow / Widower (Circle)

h) Closest Relative or Friend:

Name:____Phone:_____________________________

Address:____

City:____State:________________Zip:_________________

Relationship:____

i) Please list the Name and Date of Birth of your children, spouse, and any other dependents. Indicate N/A if none.

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j) If you are using an attorney, financial advisor, or C.P.A. for this transaction, please complete the following:

Name:____Phone:_______________________________

Address:____

City:____State:_________________Zip:__________________

k) Are you presently eligible for or receiving means based entitlements such as Food Stamps, Medicaid (Medi-Cal), or Social Security Income?
Yes____ No____ If yes, please provide details.

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l) Have you ever been a party to a bankruptcy, civil lawsuit, tax lien, or creditor lien?
Yes___ No___ If yes, please provide a brief summary and include copies of discharge papers, if applicable.

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2. INSURANCE INFORMATION

(If you are considering selling more than one policy, please photocopy this page and complete for each policy.)

a) Insurance Company:____

b) Policy Number:____

c) Face Amount of Policy:____________________________________

d) Date of issue:____

e) Type of policy: Group / Term / Whole Life / Universal Life / Group Conversion / Other (Circle)

f) Who pays premiums on the policy? Self / Employer / Waived by Insurer / Other (Circle)

g) Has the policy ever lapsed, or have you increased the face amount since the policy was issued? Yes___No___
If yes, when was it reinstated, or when was the last increase?

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h) Amount of loans against the policy:____

i) Are you the owner of the Policy? Yes_____No_____ If no, please provide the name, address, and phone number of the owner.

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j) Please provide the names, ages, and relationship to you of the beneficiaries of the policy.
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k) If this is a group policy, which company or organization was it issued through?

Organization/Employer:____

Address:____

City:____________________________________State:_______________Zip:______________

Person or department responsible for insurance matters:

Name:______________________________ Department:____________________

Phone:______________________________

Is this a current employer? Yes___ No____
When did you begin working for this employer?_____________________________________

Do we have permission to contact the above organization about your insurance?
Yes____No____

3. MEDICAL CONDITION

a) Please give a brief description of your medical condition.
(If you are HIV positive or have AIDS, please include your latest T-4 cell count, viral load and list any opportunistic infections)

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b) Are you able to work? Yes____No____
Are you still working? Yes____No____
If no, when did you last work?_______________
If you are working, do you intend to stop working soon? Yes___No____
If yes when?________________________

c) Attending Physician:____________________________________ Since:___________________

Medical Practice Name:____________________________________Phone:___________________

Address:____

City:____________________________________State:_______________Zip:______________

d) Please list the names, addresses, and phone numbers of any other doctors who may have additional information about your condition.

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e) If you have any other life insurance in force please list the face amounts and insurance company name for each policy.

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I, the Applicant, warrant and represent that all information contained in this application is true and correct to the best of my knowledge.

I, the Applicant, include a photocopy of my drivers License and one other form of picture identification, and swear and warrant that I, in fact, am that person so identified.

I, the Applicant, submit this application to Life Settlement Services, LLC with the full knowledge and understanding that Life Settlement Services, LLC is under no obligation to purchase the life insurance policy.

I, the Applicant, hereby authorize Life Settlement Services, LLC or its agents to obtain a credit report if needed.

_____________________________________ _______________________________

Signature of Insured Typed or Printed Name of Insured

State of _________________________)

____

County of _________________________)

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED before me this______________Day of

__________________20_____by____

____

Notary Public

My Commission Expires:________________________

A U T H O R I Z A T I O N

Please include this authorization to release records and policy information with this application.

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider identified below (each, an "Authorized Discloser") to provide Life Settlement Services, LLC and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representative ("LSS"), 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 Authorized Discloser to release to LSS 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.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by LSS in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish LSS with any information or forms in connection with any life insurance policy under which my life is insured (including any conversions thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

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, any of my medical information disclosed by any Authorized Discloser to LSS may be redisclosed by LSS 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 lain language and I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this Authorization.

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

AUTHORIZED DISCLOSERS:

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Name of Insured	Signature of Insured Date
Date of Birth	Social Security Number
Name of Witness	Signature of Witness Date
Name of Owner (If other than Insured)	Signature of Owner (If other than Insured) Date
Name of Witness	Signature of Witness Date

To facilitate execution, this application may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart hereof, and is shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.