



291 Main Street  
Northport, NY 11768  
Phone: 631-239-6655  
Fax: 631-239-6657  
[www.selectlife.net](http://www.selectlife.net)

## Small Face Amount Form

Please **answer all questions** for policies from \$100,000 to \$500,000.

### Insured Information

1. Name of Insured \_\_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_
2. Address \_\_\_\_\_
3. Phone Number \_\_\_\_\_
4. Date of Birth \_\_\_\_\_

### Policyowner Information

5. Name of Policyowner \_\_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_
6. Address \_\_\_\_\_

### Policy Information

7. Insurance Company \_\_\_\_\_
8. Face Amount of Policy \_\_\_\_\_
9. Policy Number \_\_\_\_\_
10. Type of Policy (only Universal Life, Convertible Term and Survivor Universal Life with one insured deceased)  
\_\_\_\_\_
11. Current Premium \_\_\_\_\_
12. Payment mode (such as Annual, Semiannual, Quaterly, Monthly) \_\_\_\_\_
13. Cash Surrender Value \_\_\_\_\_
14. Policy Issue Date (mm/dd/yyyy) \_\_\_\_\_
15. Underwriting Class (only Standard or Preferred accepted) \_\_\_\_\_

### Medical Information

16.  Yes  No In the past year, have you used tobacco products?  
Circle all that apply: Cigarettes Cigars Pipe Smokeless tobacco
17.  Yes  No Do you drink alcohol?  
If yes, how many drinks per day? \_\_\_\_\_
18.  Yes  No Do you use a cane or walker?
19.  Yes  No Do you use a wheelchair?
20.  Yes  No Have you fallen two or more times in the last year?
21.  Yes  No Do you need assistance with daily living?
22.  Yes  No Do you live in a nursing home?
23.  Yes  No Are you forgetful?  
If yes, circle all that apply: Diagnosed with memory loss Diagnosed with Alzheimer's Disease  
Taking Aricept, Namenda or Exelon
24.  Yes  No Have you been diagnosed with high blood pressure?



25.  Yes  No Have you been diagnosed with high cholesterol?
26.  Yes  No Have you been diagnosed with atrial fibrillation?
27.  Yes  No Have you been diagnosed with coronary artery disease?  
If yes, in which year? \_\_\_\_\_
28.  Yes  No Have you had a heart attack?  
If yes, in which year? \_\_\_\_\_
29.  Yes  No Do you have a pacemaker?  
If yes, in which year was it inserted? \_\_\_\_\_
30.  Yes  No Have you had a stroke?  
If yes, in which year? \_\_\_\_\_
31.  Yes  No Have you had a TIA?  
If yes, in which year? \_\_\_\_\_
32.  Yes  No Have you had heart surgery?  
If yes, please indicate year and type of heart surgery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
33.  Yes  No Have you ever been diagnosed with cancer?  
If yes, please indicate year, type of cancer and any surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
34.  Yes  No Do you have diabetes?  
If yes, do you have high blood sugar? Yes No  
If yes, is your blood sugar usually under control? Yes No
35.  Yes  No Do you have asthma?
36.  Yes  No Do you have bronchitis?
37.  Yes  No Do you have COPD?
38.  Yes  No Do you have emphysema?
39.  Yes  No Do you use oral or inhalable steroids?
40.  Yes  No Do you use oxygen?
41.  Yes  No Have you been diagnosed with Parkinson's Disease?
42.  Yes  No Have you been diagnosed with Rheumatoid Arthritis?
43.  Yes  No Have you been diagnosed with kidney disease?
44.  Yes  No Are you on dialysis?
45.  Yes  No Do you have problems swallowing?



- 46. Yes No Are you on a ventilator?
47. Yes No Do you have sleep apnea? If yes, do you use CPAP for your sleep apnea? Yes No
48. Yes No Do you have cirrhosis of the liver?
49. Yes No Have any of your organs been transplanted? If yes, please indicate year and type of transplant:
50. Yes No Do you have any other medical issues not mentioned already? If yes, please indicate other medical issues:
51. Please indicate all medications being taken:
52. Number of doctor visits in past year:
53. Height Weight

Family History

- 54. Mother's age, if living If deceased, age of death Cause of death
55. Father's age, if living If deceased, age of death Cause of death
56. Sibling's age, if living If deceased, age of death Cause of death
Sibling's age, if living If deceased, age of death Cause of death
Sibling's age, if living If deceased, age of death Cause of death
Sibling's age, if living If deceased, age of death Cause of death



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**Key Information to evaluate a potential Life Settlement:**

Prospect Name(s) \_\_\_\_\_

Agent Name \_\_\_\_\_

Agent Address \_\_\_\_\_

Agent Phone Number \_\_\_\_\_ Agent E-mail Address \_\_\_\_\_

**Please check off that you are providing all of the following:**

	Completed Pre-Qualification Worksheet (VSP-008)
	Completed Life Settlement Appraisal Form (VSP-004)
	• Medical records (as current as possible) going back for five years
	• A list of all physicians consulted during the past five years (name, address and telephone numbers) and a summary of the insured’s medical history
	• A signed copy of the Terms and Conditions
	A signed copy of the “Authorization for the Disclosure of Health Information” (VSP-003)
	A signed copy of the “Authorization for the Release of Policy Information” (VSP-007)
	A signed copy of the “Broker of Record” letter
	Verification of Coverage (VOC) (VSP-022). This form is a separate form, to be sent to insurance carrier for them to complete and send back to Veris Settlement Partners.
	A clear copy of the Driver’s License
	An in-force illustration showing level death benefit to maturity (at minimum level premium and zero cash value at maturity)
	A copy of the life insurance policy
	If the policyowner is a trust, a copy of the trust agreement
	A copy of the most recent annual statement for the policy

Once an offer has been made and accepted all of the information requested above (plus any additional information the Provider requests) must be provided before a closing document can be prepared.



## Life Settlement Pre-Qualification Worksheet

**Prospect Name(s)** \_\_\_\_\_ **Score** \_\_\_\_\_

*Please rate each category and add the points for a total score. Compare the score with the table below for a life settlement probability. (If more than one policy is being submitted, please complete this worksheet for all policies.)*

- Policy face amount must be at least \$100,000
- Carrier is rated A- or better
- Insured is US citizen

**Client age and sex:**

- 0 Points** Male age 70 or less/Female age 73 or less
- 1 Point** Male age 71-74/Female age 74-77
- 2 Points** Male age 75-78/Female age 78-81
- 3 Points** Male age 79-83/Female age 82-86
- 4 Points** Male age 84+/Female age 87+

**Medical conditions:**

- 1 Point** In good health
- 2 Points** Minor health issues—arthritis, asthma, non-recurring or diagnosed with cancer over five years ago, hypertension, hyperlipidemia, glaucoma, ulcers, minor skin disease, obesity
- 3 Points** Moderate health issues—hepatitis, atrial fibrillation, pacemaker, memory loss, diabetes, depression, COPD, multiple sclerosis
- 4 Points** Serious health issues—Alzheimer’s disease, cancer, cirrhosis, artery disease, blood diseases, heart attack (in last 18 months), stroke

**Policy type:**

- 1 Point** Joint Survivorship UL with two living insureds or Whole Life
- 2 Points** Term life (still convertible) or Variable Universal Life
- 3 Points** Universal Life
- 4 Points** Joint Survivorship UL with one deceased

**Current Cash Surrender Value:**

- 1 Point** 30%+ of the Death Benefit
- 2 Points** 20%-30% of the Death Benefit
- 3 Points** 10%-20% of the Death Benefit
- 4 Points** 0%-10% of the Death Benefit

**Outstanding loans:**

- 1 Point** 30%+ of the Death Benefit
- 2 Points** 20%-30% of the Death Benefit
- 3 Points** 10%-20% of the Death Benefit
- 4 Points** 0%-10% of the Death Benefit

**Current premiums to maturity:**

- 1 Point** 4%+ of the Death Benefit
- 2 Points** 3%-4% of the Death Benefit
- 3 Points** 2%-3% of the Death Benefit
- 4 Points** 1%-2% of the Death Benefit

**Contestability/insurable interest:**

- 1 Point** Premium financed: Non-recourse
- 2 Points** Premium financed: Recourse
- 3 Points** Not premium financed, 24-30 months from issue
- 4 Points** Not premium financed, over 30 months from issue

Final Score	Life Settlement Probability
10 points or less	Highly unlikely
11-16 points	Unlikely—please call Veris to discuss
17-22 points	Average—contact client to complete submission package
23 points or more	Highly likely—contact client to complete submission package



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## Life Settlement Appraisal Form

\_\_\_\_\_  
**Primary Insured's Name**                      Date of Birth              Sex              Marital Status              Social Security #

\_\_\_\_\_  
**Second Insured's Name**                      Date of Birth              Sex              Marital Status              Social Security #

\_\_\_\_\_  
 Primary Address                                      City, State, Zip

\_\_\_\_\_  
 Daytime Phone Number                      Evening Phone Number

Do you have a residence in another state?     Yes     No    If yes, please provide along with how many months of the year you live there:

\_\_\_\_\_  
 Address                                      City, State, Zip                                      Months of year

### Life Insurance Policy Information-Policy #1

Insurance Company	Policy Number	Date of Issue	Policy Date
Face Amount \$	Existing Policy Loan \$	Current Annual Premium \$	
Current Cash Surrender Value \$	Policy Type (circle one): Universal Life    Whole Life    Variable Life    Term    Survivor* Group              Other-		
Policyowner	Policyowner's Social Security # or Tax ID #	Drivers Lic. # (State)	
Policyowner's Address			
City, State	Zip	Phone	
Beneficiary Name and Address (1)			
(2)			
*If Survivor, are both insureds living? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, name of insured who is deceased:			

*For additional owners or beneficiaries, please attach additional sheet as necessary.  
 If policyowner is trust, please list trustee(s), addresses & phone numbers.*

Trustee \_\_\_\_\_

Address \_\_\_\_\_

(Use additional sheet as necessary for additional trustees and please attach copy of trust document and, if necessary, any amendments hereto.)



**Life Insurance Policy Information-Policy #2**

Insurance Company	Policy Number	Date of Issue	Policy Date
Face Amount \$	Existing Policy Loan \$	Current Annual Premium \$	
Current Cash Surrender Value \$	Policy Type (circle one): Universal Life Whole Life Variable Life Term Survivor* Group Other-		
Policyowner	Policyowner's Social Security # or Tax ID #	Drivers Lic. # (State)	
Policyowner's Address			
City, State	Zip	Phone	
Beneficiary Name and Address (1)			
(2)			
*If Survivor, are both insureds living? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, name of insured who is deceased:			

*For additional owners, please attach additional sheet as necessary.*  
*If policyowner is trust, please list trustee(s), addresses & phone numbers.*

Trustee \_\_\_\_\_

Address \_\_\_\_\_

(Use additional sheet as necessary for additional trustees and please attach copy of trust document and, if necessary, any amendments hereto.)

	<b>Policy #1</b>	<b>Policy #2</b>
Has the policyowner ever declared bankruptcy?	Yes or No	Yes or No
Has policyowner been divorced?	Yes or No	Yes or No
Is the policyowner currently a defendant in a legal proceeding?	Yes or No	Yes or No
Was the policy financed?	Yes or No	Yes or No
If so, by which financing company?	_____	



<b>Primary Insured Medical Information</b>		
<i>Brief Description of Insured Medical History and Condition(s)</i>		
Primary Physician Name	Address	
City, State	Zip	Phone
Date and reason last seen		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		

*For additional specialists, please attach additional sheet as necessary.*

**Hospital Information**

If hospitalized in the past five years, please fill in the following:

Hospital (include city and state)	Condition	Length of stay
1		
2		
3		
4		



**Primary Insured Medical Information**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you ever had any of the following?

- |  |                                       |  |   |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Chest Pain/Tightening | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB/Lung Disorder   |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Stroke/TIA   | <input type="checkbox"/> Skin Disorder       | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Cataracts          |
| <input type="checkbox"/> Dementia              | <input type="checkbox"/> Depression   | <input type="checkbox"/> Digestive Problems  | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Blood in Stool        | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Dizzy Spells          | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Memory Loss        |

Please provide any additional details on the above conditions: (Attach a separate sheet if more space is needed)

\_\_\_\_\_

\_\_\_\_\_

Current prescribed medications \_\_\_\_\_

Do you exercise, and if so, how much? \_\_\_\_\_

Places travelled in past five years (both business and personal) \_\_\_\_\_

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco, i.e. chewing tobacco?

If so, please describe: \_\_\_\_\_

**Primary Insured Family History**

Have family members had:	Father	Mother	Siblings		If Living Age	If Deceased Age and Cause of Death
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brother(s)		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sister(s)		
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Autoimmune Disease/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

**Important Notice: 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.**



<b>Second Insured Medical Information</b>		
<i>Brief Description of Insured Medical History and Condition(s)</i>		
Primary Physician Name	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		

*For additional specialists, please attach additional sheet as necessary.*

**Hospital Information**

If hospitalized in the past five years, please fill in the following:

Hospital (include city and state)	Condition	Length of stay
1		
2		
3		
4		



**Second Insured Medical Information**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you ever had any of the following?

- |  |                                       |  |   |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Chest Pain/Tightening | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB/Lung Disorder   |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Stroke/TIA   | <input type="checkbox"/> Skin Disorder       | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Cataracts          |
| <input type="checkbox"/> Dementia              | <input type="checkbox"/> Depression   | <input type="checkbox"/> Digestive Problems  | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Blood in Stool        | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Dizzy Spells          | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Memory Loss        |

Please provide any additional details on the above conditions: (Attach a separate sheet if more space is needed)

\_\_\_\_\_

\_\_\_\_\_

Current prescribed medications \_\_\_\_\_

Do you exercise, and if so, how much? \_\_\_\_\_

Places travelled in past five years (both business and personal) \_\_\_\_\_

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco, i.e. chewing tobacco?

If so, please describe: \_\_\_\_\_

**Second Insured Family History**

Have family members had:	Father	Mother	Siblings		If Living Age	If Deceased Age and Cause of Death
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother		
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brother(s)		
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Autoimmune Disease/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sister(s)		

**Important Notice: 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.**



***Terms and Conditions:***

Select Life Settlement Corporation is in the business of arranging life settlement transactions, and is licensed as a life insurance agent and/or Life Settlement/Viatical Broker as required in the various states in which we conduct business. Once we accept your application, we bear all the expenses associated with the transaction, including but not limited to obtaining medical records and life expectancy studies, policy analysis, modeling, and preparing and maintaining a complete file for submission to the marketplace and for regulatory compliance purposes. We then make a diligent effort to stimulate competing bids in attempt to provide the highest possible value for each policy offered into the secondary market. Select Life Settlement Corporation is acting solely on your behalf in this transaction; we do not in any way represent the purchaser of the policy other than in soliciting and delivering offers on your behalf, and assisting in the closing process once an offer is accepted by you.

Select Life Settlement Corporation is compensated for its services on a “success” basis. Unless an acceptable offer is obtained by us and accepted by you no fees or commissions are payable. If you do accept an offer presented by Select Life Settlement Corporation, we will receive a portion of the gross purchase price in compensation for services rendered. Such compensation shall not in any event exceed the lesser of 8% of the face amount of the policy or 30% of the gross purchase offer. Additionally, the following minimum compensation levels have been set based on the policies face amount. These are: face amount less than \$249,999 has minimum compensation of \$2,500; face amount of \$250,000 to \$499,999 has minimum compensation of \$5,000; face amount of \$500,000 to \$999,999 has minimum compensation of \$7,500; and face amount of \$1,000,000 and above has a minimum of \$10,000. If you have been referred to us by your insurance agent or other representative, they may be entitled to share in such compensation.

**I hereby accept these terms and conditions and authorize and appoint Select Life Settlement Corporation to act exclusively on my/our behalf for the purposes of securing a life settlement on the policies described within this application. This appointment shall be valid for 120 days unless notice of termination is given to Select Life Settlement Corporation in writing. I also acknowledge that I have received the Required Notice (form SLSP-021) included with this application.**

\_\_\_\_\_  
 Signature of Owner 1

\_\_\_\_\_  
 Signature of Owner 2

\_\_\_\_\_  
 Printed Name of Owner 1

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Owner 2

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Insured 1

\_\_\_\_\_  
 Signature of Insured 2

\_\_\_\_\_  
 Printed Name of Insured 1

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Insured 2

\_\_\_\_\_  
 Date

It is your responsibility to continue paying premiums until the life settlement transaction is completed. The policy cannot be sold if it is in pending lapse or grace; therefore, the premiums must be current.



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## Authorization for Disclosure of Protected Health Information (HIPAA Compliant)

### For Life Settlement

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 (“PHI”) 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 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 Select Life Settlement Corporation, American Viatical Services, Inc., Fasano Associates, Inc., Examination Management Services, Inc., 21st Services, including any of their affiliates, agents, subsidiaries, corporate parents, independent contractors, authorized representatives, service providers, life settlement providers and the officers, directors, and employees of each (each an “Authorized Recipient”). I understand that my PHI may be secured by a third-party provider 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, records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purpose of allowing authorized recipients (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, certificate of life insurance, under which my life is insured to the authorized recipient and (2) to monitor, track, and verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacement therefore, that Select Life Settlement Corporation brokers.
4. Expiration: This authorization shall remain valid until one (1) year after the date of my death.
5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any authorized HCP by notifying such authorized HCP 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; provided, that any revocation of this authorization shall not apply to the extent that the authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.



6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provisions 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 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 potential for my PHI that is disclosed by an authorized HCP to an authorized recipient to be subject to redisclosure by an authorized recipient and my PHI that is disclosed to such authorized recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I executing and delivering this authorization freely and unilaterally 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 a copy of this signed authorization for future reference.

---

Signature of Insured 1

---

Printed Name of Insured 1

Date

---

Signature of Insured 2

---

Printed Name of Insured 2

Date

---

Signature of Witness

---

Printed Name of Witness

Date



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## Authorization for Release of Policy Information

I hereby request and authorize \_\_\_\_\_, the insurer of life insurance Policy Number \_\_\_\_\_ and/or Certificate Number \_\_\_\_\_ owned by \_\_\_\_\_

[Insert name of policyowner(s)], and insuring the life of \_\_\_\_\_ [Insert name of Insured(s)], to release to Select Life Settlement Corporation and/or its authorized agents, successors, assignees and affiliates, and their authorized representatives, any and all information concerning the above policy (including any conversion thereof or replacement therefore). This includes, but is not limited to, complete copy of all policies and policy forms, master policies and certificates for any group policies, all applications, policy illustrations, verification of coverage forms, change of beneficiary forms, and collateral and/or absolute assignment forms, as well as other information reflecting ownership and benefits payable under the policy, liens and assignments, premium waivers, and all provisions of the policy related to the foregoing.

This Authorization shall be effective from the date of signature until expiration of two (2) years following the death of the Insured(s). However, if any governing law or regulation limits this authorization to a shorter period of time, then Release shall remain in force for the maximum period of time allowed by law.

I agree that any copy or facsimile of this Authorization shall be valid as the original.

This Authorization may be signed in counterparts if required to complete execution. This Authorization is effective as to each insured and each policyowner and is not conditioned upon signature by other insureds or policyowners. It shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.

\_\_\_\_\_  
Signature of Policyowner

\_\_\_\_\_  
Signature of Policyowner

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date





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## **Required Notice**

### **Important Information You Need to Know Before Entering Into a Life Settlement**

#### **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 who is insured under the policy is called a life settlor. This person may or may not be the owner of the policy. Only the owner of the policy has the right to sell the policy. If you do not own the policy, the owner cannot sell the policy without your consent. The entity that buys the policy is called a life settlement provider (hereafter referred to as provider) and must have a registration from your state's Department of Insurance. Additionally, there are persons called brokers or provider representatives, who help with the sale of the policy. The provider representative or broker must also have a registration from your state's Department of Insurance.

A life settlement offers you the opportunity to receive a portion of your policy's death benefit while you are still alive.

#### **How do life settlements work?**

Most providers, provider representatives, or brokers will ask you to complete an application and medical release forms so that 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 life settlement contract.

#### **Do I have to sell all of my policy?**

No. You can sell all of your policy or you can sell only a part of your policy. If you sell only a part, you will be required to assign or transfer only the part being sold. If you sell the entire policy, the provider will become the new owner of the policy.

#### **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. A broker will check with several providers to find the best offer for you. A provider representative works for a provider. A



provider representative will only check with the provider that 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, a spouse, or a significant other, may not be shared with anyone unless you have given written approval that the information may be shared. Any written approval for the sharing of this information must show who may get the information and why it will be released.

**If I enter a life settlement contract, when will I get my money and who from?**

The answer to this question depends on how the provider runs its business. Some 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.

**What if I change my mind?**

If you change your mind about selling your policy, most states have a rescission period after you receive the money from the provider. The guidelines for any rescission period will be explained in detail in the Life Settlement Purchase and Sale Agreement, which can vary on a state to state basis.

**What if I die shortly after selling my policy?**

After you receive the money from the provider, if you die at any time during any rescission period (which would be explained in detail in the Life Settlement Purchase and Sale Agreement), the settlement contract will automatically cancel. The provider will pay the owner of your policy or beneficiaries designated by the owner in the 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 provider has paid the owner for the sale of the policy, they may begin calling to check on the health status of the 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 your contact person for more than 30 days. If you need to, 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 and how often can they call?**

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.

If your life 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 on my health status?**

Some providers will use your signed medical release form to check with your doctor for updates on your health status. The medical release form tells your doctor that you want your doctor 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 coverages like accidental death, future increases in the death benefit, or covers other family members? Do these affect my settlement?**

Some policies contain extra coverages. You may want to contact your insurance company or agent to see if your policy contains a provision or rider providing extra coverages.

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 life settlement, you should contact your insurance company or agent to see what options are available.

**What other things should I know about a life settlement contract?**

Some things that may be affected if you enter a life settlement are:

- there may be a loss of life insurance coverage on your spouse or other family members, if the policy (or any riders attached to it) covers their lives;
- the amount of premiums you pay;
- policy cash values or dividends, if provided for in the policy;
- a loss of other rights or benefits, including conversion rights and waiver of premium benefits that may exist under your policy;
- you may incur tax consequences;
- your ability to receive supplemental social security income, public assistance, and public medical services including Medicaid; and
- the money you receive for your life settlement could be taken away 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.

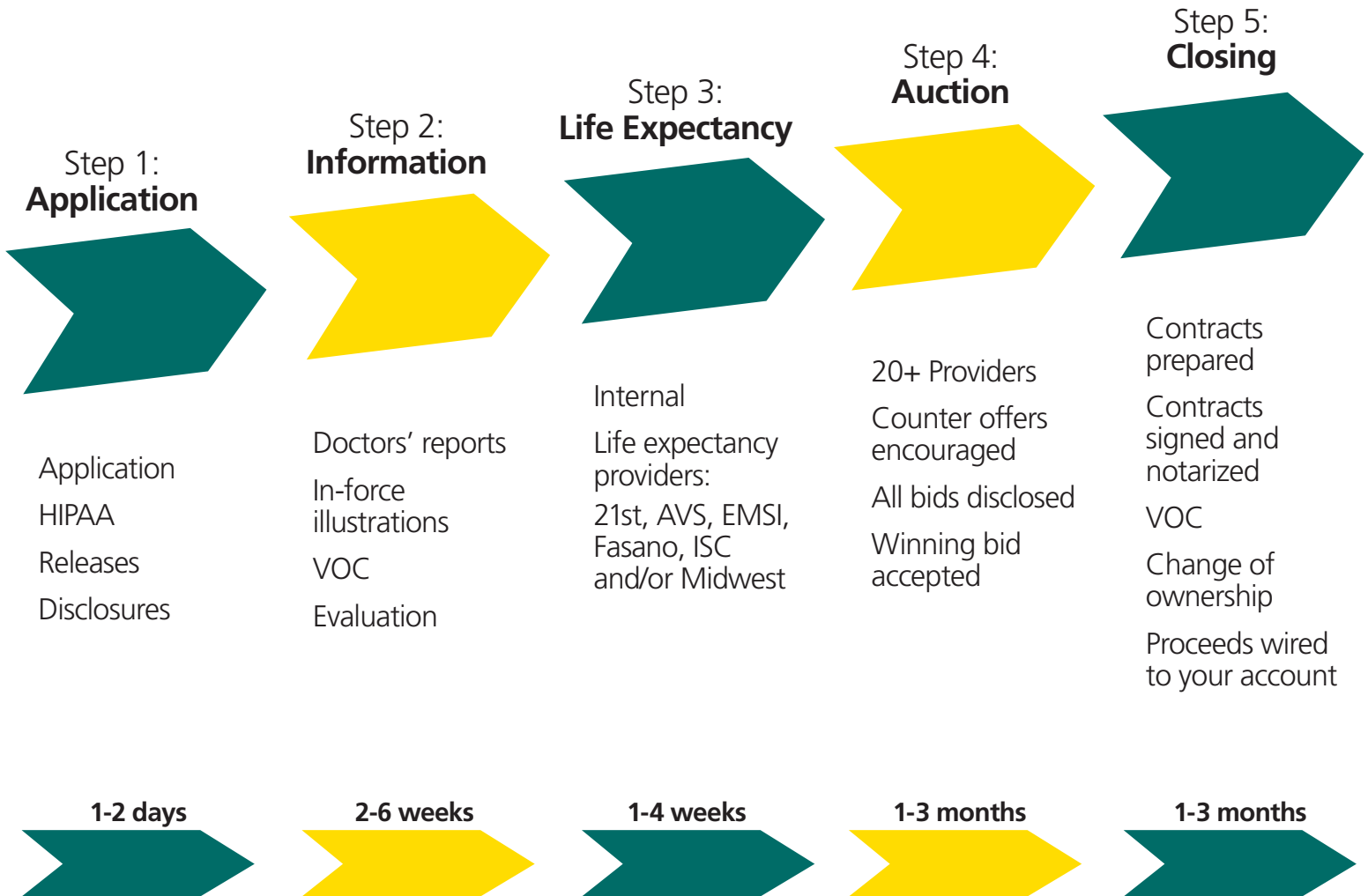
**What if I have a complaint?**

You may file a complaint with the Department of Insurance in your state.



291 Main Street  
 Northport, NY 11768  
 Phone: 631-239-6655  
 Fax: 631-239-6657  
[www.selectlife.net](http://www.selectlife.net)

## Life Settlement Process



## Please Deliver Immediately

Attention: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
From: \_\_\_\_\_ Date: \_\_\_\_\_  
Re: Policy # \_\_\_\_\_ Pages: \_\_\_\_\_

Please provide complete Verification of Coverage (VOC) for policy # \_\_\_\_\_ on the life of \_\_\_\_\_. This VOC statement should at a minimum include the following policy information:

### Owner and Insured Information

Name of insured(s)  
Insured(s) date of birth  
Name of policyowner(s)  
Policy date of issue  
State of issue

### Premium Information

Current payment mode  
Current model premium  
Date last premium paid  
Date next premium due

### Policy Type and Information

Policy type  
List current riders  
Policy values "as of" date  
Current face amount of policy  
Current account value  
Current cash surrender value  
Policy status  
Any current policy assignments  
Current loan balance

Please fax Verification of Coverage (VOC) to me at 631-239-6657. The original VOC should be mailed to me at the address on file.

Thank You,

\_\_\_\_\_  
Policyowner's Signature

\_\_\_\_\_  
Print Policyowner's Name

This will be the **ONLY** form of transmittal pertaining to this matter.

Hard copy to follow.

If any transmittal problems occur, please phone 631-239-6655.

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