



Small Face Amount Simplified Underwriting Supplement

Please **answer all questions** for all policies with a Face Amount of \$500,000 and below.

Insured Information

1. Name of Insured _____ SS#: _____ Date of Birth ____/____/____
2. Height _____ Weight _____ Gender: ___ Male ___ Female
3. Marital Status ___ Single ___ Married ___ Divorced ___ Legally Separated ___ Widowed
 ___ Other (if other, please specify _____)
4. Are you a US Citizen or Resident ? ___ Yes ___ No If No, which country? _____

Insured's Lifestyles and Habits

5. Yes No Has your weight changed in the last year?
 If yes, provide details: _____
6. Yes No Do you currently smoke or have you ever smoked cigarettes?
 If yes, indicate how many daily: _____ Date of last use: _____
7. Yes No Do you use any other form of tobacco?
 If yes, indicate type and frequency: _____
8. Yes No Do you drink wine or spirits?
 If yes, indicate type and number of drinks per day: _____
9. Yes No Are you currently employed?
 If yes, indicate occupation: _____
10. Yes No Are you involved in hobbies, clubs, organizations or volunteer work?
 If yes, provide details of type and frequency: _____
11. Yes No Do you have a valid Driver's License?
 How many car accidents have you been involved in during the past two years? _____
12. Yes No Do you currently engage in sports or regular exercise?
 If yes, provide details of type and frequency: _____
13. Yes No Do you live alone?
 If no, do you live with spouse or significant other? _____
14. Yes No Do you live in an assisted living facility or nursing home?
15. Yes No Are you the primary caregiver for a dependent family member?
 If yes, please provide details: _____
16. Yes No Do you require assistance to perform any of the following activities? (circle all that apply)
 Meal planning Taking medication Driving Shopping
 Walking Bathing Dressing
 If yes, please provide details: _____
17. Yes No Do you use any non-prescription alternative treatments such as herbal remedies?
 If yes, provide details of type and frequency: _____

18. Yes No How many of the following do you participate in two or more times per week?
(circle all that apply)

Reading	Walking	Crossword puzzles	Swimming	Cooking
Checkers/chess	Tennis	Golf	Bicycling	Knitting
Singing	Jogging	Using e-mail	Playing a musical instrument	
Reading the newspaper	Using a computer			

19. Yes No Are you currently involved in any litigation?

20. Yes No Have you been party to a bankruptcy or similar proceedings since the policy issue date?

Insured's Medical History, Conditions and Treatments

In the past five years, have you been diagnosed with or treated for any of the following conditions?
(circle all that apply)

21. Yes No Disease or disorder of the heart including high blood pressure, irregular pulse, heart attack, coronary artery disease, chest pains, angina or other heart disorder?

22. Yes No Circulatory or blood vessel disorder, including stroke, TIA (mini-stroke), arterial blockage in the neck, abdomen or legs, blood clots, aneurysm or any other?

23. Yes No Cancer, tumor or malignancy?

24. Yes No Any immune system disorder?

25. Yes No Disease or disorder of the digestive system including diabetes, liver disease, colon, intestinal, stomach disorder or any other?

26. Yes No Infectious disease (other than common colds and flus) including hepatitis, pneumonia, sexually transmitted disease, shingles or other?

27. Yes No Disease or disorder of the lungs or respiratory system including asthma, emphysema, COPD, chronic bronchitis, shortness of breath or any other?

28. Yes No Genitourinary problems including disease or disorder of the genitalia, breasts, prostate, bladder, kidney or any other?

29. Yes No Abnormality of the blood and platelets including anemia, high cholesterol or any other?

30. Yes No Bone or joint abnormality, paralysis, trauma, injury or physical impairment, including problems with balance or walking?

31. Yes No Neurological disorders including Parkinson's disease, multiple sclerosis, loss of consciousness, convulsions or epilepsy, loss of vision or hearing, neuropathy, chronic pain or any other?

32. Yes No Mental or nervous disorder including memory or cognitive impairment, dementia, psychiatric disorder or any other?

33. Yes No Have you ever been treated for alcohol or drug abuse, or told by a physician or practitioner to reduce or eliminate alcohol or drug use?

34. Yes No Have been diagnosed with, been treated for, had surgery or are currently being treated for any other disease or disorder not previously given?



If you answered "yes" to any of questions 21-34, please provide details below. Attach an additional page if necessary.

Question # ___ Diagnosis _____ Date last treated ___/___/___ Name of doctor or hospital _____
 Results _____

Question # ___ Diagnosis _____ Date last treated ___/___/___ Name of doctor or hospital _____
 Results _____

Question # ___ Diagnosis _____ Date last treated ___/___/___ Name of doctor or hospital _____
 Results _____

35. Mother's age, if living _____ If deceased, age at death _____ Cause of death _____

36. Father's age, if living _____ If deceased, age at death _____ Cause of death _____

37. Sibling(s) age, if living _____ If deceased, age at death _____ Cause of death _____

38. Please list all prescription medications currently being used:

39. Please provide the name and address of your primary care physician, noting date and reason last seen:
 Name _____ Address _____
 Date last seen ___/___/___ Reason for visit _____

In addition to this questionnaire, an independent Life Expectancy (LE) Underwriting provider, IBU, Inc., may contact the insured by telephone to conduct an interview consisting of general medical and health questions, which takes approximately 20 to 30 minutes. The information is then forwarded to their underwriting staff who reviews the information and determine the LE. This process expedites the turnaround time on LEs and allows us to streamline the policy valuation process. Please complete the following authorization so that IBU may conduct an interview and provide an LE, if necessary.

Authorization to Obtain Life Expectancy Report

I, _____, (name of insured) authorize IBU to contact me to conduct an interview in order to provide a Life Expectancy Report which will be used in connection with valuating my Life Insurance policy # _____ (policy number) issued by _____ (insurance company) for the purposes of a Life Settlement transaction.

Phone Number: _____ Best time to call: _____



The undersigned insured and agent hereby represent and warrant that any and all information provided in this questionnaire is true and correct as of the date hereof. Each undersigned hereby affirms its understanding that Veris Settlement Partners, Inc. and or its affiliates, directors, officers, employees, agents, independent contractors, service providers, life settlement providers or other authorized representatives (“Veris”) will be relying on the statements and responses which are being provided by the undersigned in this questionnaire, and each undersigned agrees, jointly and separately, to hold Veris harmless and agrees to indemnify Veris from and against any loss, liability, expense, claim or demand arising out of or in conjunction with any such statement or response.

I understand that it is a crime to knowingly present false, inaccurate, incomplete or misleading information to, or conceal information related to an application for insurance or for life settlement from, an insurance company or a life settlement provider for the purpose of defrauding such company. Penalties may include imprisonment, fines, denial of benefits and civil damages. I understand that Veris has in place anti-fraud initiatives designed to detect and prevent fraud, and may report cases of suspected fraud to the appropriate legal and regulatory authorities or insurance companies.

Name of insured	Signature of insured	Date
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Name of agent	Signature of agent	Date
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