



LIFE SETTLEMENT APPLICATION

A. PERSONAL INFORMATION - INSURED (PRINT OR TYPE)

Name of Insured: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

If Married, Name of Spouse: _____ Dependent Children? _____

Complete for Second Insured, if applicable.

Is the Second Insured deceased? _____

Name of Insured: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

If Married, Name of Spouse: _____ Dependent Children? _____

A. MEDICAL INFORMATION

Medical History Summary of Insured:

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Complete for Second Insured, if applicable.

Medical History Summary of Insured:

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

For additional medical or physician information, please provide a supplementary page.

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B. LIFE INSURANCE INFORMATION

Insurance Company _____ Policy Number _____

Face Amount: _____ Date of Issue: _____

Policy Type (Term, UL, WL, SUL, SWL, VUL, Other): _____

Annual Premium Amount: _____ Premium Due Date: _____

Last Premium Paid Date: _____ Amount Paid: _____

C. PERSONAL INFORMATION – OWNER

Is the Insured also the Owner? _____

Is Owner the payor of premiums for the policy? _____

If not:

Who is the payor of premiums for the policy? _____

Relationship of Premium Payor to Owner and Insured _____

Complete if Owner is an individual not also the Insured.

Name of Owner: _____

Authorized Representative (if business): _____

State of Formation (if business): _____

Relationship to Insured: _____

Date of Birth: _____ SSN/TIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Driver's License Number: _____ State of Issue: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

If Married, Name of Spouse: _____

Is the Owner a defendant in any suits or legal actions? _____

Has the Owner ever declared bankruptcy? _____

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D. PERSONAL INFORMATION – BENEFICIARY(IES)

Name of Beneficiary: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

Is Beneficiary a Revocable or an Irrevocable beneficiary of policy _____

Complete for Second Beneficiary , if applicable.

Name of Beneficiary: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

Is Beneficiary a Revocable or an Irrevocable beneficiary of policy _____

Please complete the following questions.

1. Has the Policy Owner changed since the policy was issued? _____

If yes, please list name of initial Policy Owner: _____

2. Name of current Beneficiary: _____

Relationship to Insured and Owner: _____

3. Has Beneficiary changed since the policy was issued? _____

If yes, please list name of initial Beneficiary: _____

Relationship to Insured and Owner: _____

4. What was the Insured's and Policy Owner's original purpose for buying the policy? Explanations such as "estate planning" should be expanded upon.

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Please complete the following questions continued.

5. Before or at the time the policy was issued, did the Insured, Policy Owner or any other party arrange to transfer, sell or assign, directly or indirectly the policy or any benefits to a third party? _____

If yes, describe the arrangement in detail and provide copies of documents relating to the arrangement.

6. Has the Policy Owner ever collaterally assigned the policy or policy benefits to any person or entity? _____ If yes, describe the details of such assignment.

7. Has the policy or any of the policy premiums been financed by a third party, either through a loan, equity contribution or otherwise? _____

If yes, please describe the financing arrangement in detail and provide copies of any document related to that arrangement.

If yes, name of Lender or Equity Contributor: _____

Principal loan or equity contribution amount: _____

Loan Maturity balance (*payoff amount*): _____

Loan Maturity date: _____

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8. List all persons or entities (including any trust) who have, or have had, any direct or indirect ownership or other interest in the policy or its proceeds, including the nature of the interest and the relationship of such person entity to the insured. For any entity, please identify all persons that own (or have owned) and, if different, control or manage (or have controlled or managed) that entity. For any trust, include all beneficiaries to the trust.

Name: _____

Nature of the interest: _____

Date and manner interest was obtained: _____

Relationship to insured: _____

Name: _____

Nature of the interest: _____

Date and manner interest was obtained: _____

Relationship to insured: _____

Name: _____

Nature of the interest: _____

Date and manner interest was obtained: _____

Relationship to insured: _____

The undersigned represents to Life Settlement Hub that:

- A. All the information contained herein is complete and accurate and may be relied upon by Life Settlement Hub LLC (“LSH”) and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives
- B. The undersigned will immediately notify LSH of any material change in any information contained herein, occurring prior to conclusion of the proposed policy sale, including but not limited to: lapse, surrender or rescission of the policy, assignment of ownership or collateral assignment of the policy, and any change in beneficiary or creation of irrevocable beneficiary of the policy.

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FRAUD WARNING

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE SETTLEMENT CONTRACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO APPLICANTS

Neither LSH nor its officers, directors, or principals provide legal, accounting, estate planning, tax or financial advice to prospective applicants regarding the advisability or relative merits of selling a life insurance policy.

An Owner must determine the benefits, detriments, risks and tax consequences of selling a life insurance policy solely in reliance upon the Owner's own attorney, accountant, or other appropriate professional advisors, only then, should a decision be made to sell a life insurance policy.

Owner has a clear and complete understanding of the current or future benefits of the life insurance policy being considered for sale. Each of the Owner and Insured(s) acknowledges that he/she has freely and voluntarily provided the information requested in this application.

The undersigned acknowledges they have read and fully understand this Life Settlement application.

OWNER/SELLER

Signature: _____
Printed Name: _____
Date: _____

OWNER/SELLER

Signature: _____
Printed Name: _____
Date: _____

INSURED

Signature: _____
Printed Name: _____
Date: _____

INSURED

Signature: _____
Printed Name: _____
Date: _____

**AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION
PERMISSION TO SHARE INFORMATION**



Patient's Name <i>(please print)</i> :	Date of Birth:	Medical Record Number <i>(if known)</i> :
Address:	Telephone Number:	Social Security Number:

Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From / Between (Circle):	To / Between (Circle):
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Fax Number: _____	Fax Number: _____
Telephone Number: _____	Telephone Number: _____

I, _____ **(Name of Individual)**, authorize 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, Pharmacy Benefit Manager, any other type of health care provider, and any other person, company or institution (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 a photo static 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 Life Settlement Hub LLC ("LS Hub"), any of their affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for Disclosure: 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. This information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, Page 2

4. Purpose of Disclosure: This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition and life expectancy in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured and (2) to monitor, track or verify my life, health or medical status and condition in connection with any life insurance policy under which my life is insured.

5. Expiration: I understand this authorization will remain until the later of two (2) years after the date of my signature below or one (1) year after the date of my death.

6. 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; or by notifying LS Hub LLC in writing, addressed as set forth below. Notices shall be deemed given as of the date received or on the date shown on the receipt or confirmation therefor.

LS Hub Mailing Address: Life Settlement Hub, 1614 SE 10th Ave, Deerfield Beach, FL 33441

7. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision 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 the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the 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 am 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 and retained a copy of this signed authorization for future reference.

PATIENT OR INDIVIDUAL

PERSON AUTHORIZED TO SIGN ON BEHALF OF PATIENT OR INDIVIDUAL

Signature: _____

Printed Name: _____

Date: _____

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

(For example: Power of Attorney, Guardian ad Litem or similar status. Please attach a copy any official document confirming this status.)



LIFE INSURANCE INFORMATION RELEASE FORM

Policy Owner: _____
Insured: _____
Policy Number: _____
Insurance Carrier: _____

I hereby authorize my insurance company to furnish Life Settlement Hub LLC, and/or any of their affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, any and all information, verbal or written, including any life insurance policy illustrations, verifications of coverage, policy and application forms, riders or amendments related to the life insurance policy identified above.

I specifically authorize and request my life insurance company to rely upon a photo static or facsimile copy or other reproduction of this authorization as valid as the original authorization.

I agree and acknowledge this authorization shall remain valid for two (2) years after the date of my signature below.

POLICY OWNER

POLICY OWNER

Signature: _____
Printed Name: _____
SSN/Tax ID: _____
Date: _____

Signature: _____
Printed Name: _____
SSN/Tax ID: _____
Date: _____



AUTHORIZATION OF POLICYHOLDER AND INSURED
FOR USE AND DISCLOSURE OF NON-PUBLIC PERSONAL INFORMATION
FOR EFFECTUATION OF A LIFE SETTLEMENT TRANSACTION

In order to effect a potential life settlement contract for Life Insurance Policy Number _____ owned by _____ (“Policyholder”) insuring the life of _____ (“Insured”) (the “Policy”), each of the undersigned Policyholder and Insured hereby irrevocably authorizes Life Settlement Hub LLC, any of their respective affiliates and any of their respective directors, officers, managers employees, agents and successors and assigns (collectively, the “LSH Parties”) to use, and to deliver, disclose, give, provide and release, any and all information, including without limitation, non-public personal financial and health and medical information about the Policyholder and the Insured, including their identities as the owner of or insured under the Policy, that any of the LSH Parties obtain, whether from the Policyholder or the Insured, any of their agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source, to any (1) life settlement provider and its employees, agents and representatives and their respective successors and assigns (collectively, a “Life Settlement Provider”) or (2) any other person or entity that can under applicable law purchase the Policy without being a licensed life settlement provider, as may be necessary to effect a life settlement of the Policy.

Further, each of the undersigned hereby irrevocably authorizes each Life Settlement Provider to use and deliver, disclose, give, provide and release, any and all information, including, without limitation, nonpublic personal financial and health and medical information about the Policyholder and the Insured, including their identities as the owner of and insured under the Policy, that such Life Settlement Provider may obtain from any of the LSH Parties, to any financing entity, investor customer or any financing source of such Life Settlement Provider as may be necessary to effect a life settlement of the Policy.

Each of the undersigned hereby agrees and irrevocably consents that this Authorization shall be effective from the date hereof until two (2) years after the date hereof. Each of the undersigned hereby agrees that any photocopy, facsimile or other reproduction of this Authorization shall be as valid as the original hereof and may be relied upon by any person or entity.

INSURED

Signature: _____

Printed Name: _____

Title: _____

Date: _____

POLICY OWNER

Signature: _____

Printed Name: _____

Title: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Title: _____

Date: _____