

Our best offer — The first time

Everytime™



**Committed to Excellence in the Secondary
Market for Life Insurance**

APPLICATION

For Life Settlement or Viatical Settlement



please print applicant's (insured) name

To obtain the best amount for your life insurance
policy, read and thoroughly complete these forms.

www.lifeselementproviders.com

866-509-5534

Please print or type.

INSURED PERSONAL INFORMATION

Full Name

Social Security #

Address

City

State

ZIP Code

Home Phone

Work Phone

Cell Phone

Birth Date

Marital Status

Gender

Please list the names and ages of all dependents.

Name

Age

Please list your present or last place of employment.

Please list your present or past occupation(s).

LIFE INSURANCE POLICY INFORMATION

Insurance Company's Name

Policy #

Death Benefit

Issue Date

Loan Amount

Owner of Policy

Owner's Address

Please list the names of beneficiaries.

Name

Relationship

Insurance Company's Name (if more than one policy)

Policy #

Benefit Amount

Issue Date

Owner of Policy

Please list the names of beneficiaries.

Name

Relationship

Applicant Initial  _____

MEDICAL INFORMATION

Primary Care Physician

Address

City

State

ZIP Code

Telephone Number

Fax Number

Please give a brief description of your medical condition.

Please list any other physicians and their phone numbers that you have seen in the last 5 years.

Physician

Telephone Number

FINANCIAL INFORMATION

Answering yes to any of the following questions will not disqualify you.

Have you at any time declared bankruptcy? Yes No

If yes, enclose a copy of the discharge (if available) or identify the case number and court in which the case was filed.

Are you now or have you ever been party to a civil lawsuit? Yes No

Do you have any judgments against you? Yes No

Do you have any tax lien or creditor liens? Yes No

Are you currently receiving any means based entitlement such as Medicaid, food stamps, or supplemental security income from the Social Security Administration? Yes No

Remarks (If more space is required, please attach additional pages.)

Applicant Initial 

I am the owner and/or insured of policy number _____
issued by _____.

At present: (Please initial and complete all that apply.)

_____ I am single, never married.

_____ I am married.

My spouse's name is _____.

_____ I am divorced.

☞ If I am divorced I understand that I am obligated to attach a complete copy of the dissolution of marriage, together with any or all property and/or settlement orders.


_____ I am widowed.

_____ I have no children.


_____ I have minor children.

_____ I have no minor children. All of my children are of legal age.


I am above the age of twenty-one, am mentally competent, and certify under penalties of perjury that the statements made herein are true, correct, and accurate.



Signature of Owner



Print Name of Owner



Date

The undersigned represents to Life Settlement Providers, LLC. that:

I have full and complete mental capacity to fully understand the nature and effect of the transaction, namely the viatication (selling or assigning the rights to a life insurance policy's death benefits to a third party) of the life insurance policy.

I hereby represent and warrant that all of the information contained in this application is true, correct, and accurate. I understand that Life Settlement Providers, LLC will rely on the information contained in this application, and I agree immediately to notify Life Settlement Providers, LLC if I become aware that any of the information provided herein is untrue, incorrect, or inaccurate. I further give my consent to Life Settlement Providers, LLC and its agents to release this application and any information contained in this application or received while processing this application, including, but not limited to, all medical records, notes, and lab reports, for the purpose of soliciting the sale and/or viatication of my life insurance policy. I acknowledge that I am submitting this application to Life Settlement Providers, LLC concerning the sale of my life insurance policy and that Life Settlement Providers, LLC is under no obligation to purchase my policy.

X _____
Signature of Insured Date

X _____
Signature of Policy Owner (if not insured) Date

X _____
Printed Name Date

X _____
Printed Name Date

X _____
Signature of Producer as Witness Date

X _____
Printed Name of Producer

Producer Code#

FRAUD WARNING

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

Life insurance policy number _____ issued by _____

(Insurance Company), is owned by _____, and insured the life

of _____.


I authorize the release to Life Settlement Providers, LLC ("LSP") or its designee, of any or all information concerning the above policy.


I authorize LSP to share this information with life settlement providers, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for life settlements and/or the sale of life insurance policies.


I understand that the information authorized for release may include insurance policy information, including, but not limited to, forms, riders, and amendments concerning the policy. I understand that funding sources will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policies of which I am the owner or insured. I agree that a photographic copy or facsimile of this Authorization shall be as valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.


Dated at _____ on ____/____/____
City State Mo/Day/Year


 _____
Signature of 1st Insured Date


 _____
Signature of Policy Owner Date


 _____
Printed Name Date

 _____
Printed Name Date

 _____
Second Insured (if any) Date

 _____
Signature of Witness Date

 _____
Printed Name Date

 _____
Printed Name Date

1. I (the undersigned) authorize _____
(Attending physician/healthcare provider)
- (Complete b&c only if more than one provider.)
- b) _____
(Attending physician/healthcare provider)
- c) _____
(Attending physician/healthcare provider)

To release information from the record(s) of:

2. Patient Name: _____
(Last) (First) (Middle)
- Date of Birth: _____ SS#: _____

Covering the period(s) of treatment for the past 5 years.

3. Information to be released:
- Progress Notes
 - Discharge Summary
 - EKGs
 - Operating/Procedure Reports
 - Diagnostic Tests
 - Other: _____
 - Lab Reports
 - History & Physical
 - Complete Medical Record (includes information regarding referral documents and records from other facilities.)


4. Information to be released to:
- MediConnect, Inc. AND Life Settlement Providers, LLC
10705 South Jordan Gateway, Suite 100 6302A North Point Road
South Jordan, UT 84095 Baltimore, MD 21219-1015

5. I agree that this Authorization shall remain valid unless or until I revoke it in writing, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder. I understand that I may revoke this authorization in writing at any time.

6. I understand that this consent is to include disclosure of: (PLEASE INITIAL):
- _____ Alcohol and/or drug abuse records _____ Psychiatric records
_____ Sexually transmitted disease information _____ HIV/AIDS information

7. A photocopy of this authorization is to be considered as valid as the original.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

SIGNATURE OF PATIENT  _____ Date: _____
Patient or Legal Representative

PRINT NAME: _____

Relationship to patient of the representative who signed for the patient: _____

_____ Date: _____

The undersigned insured (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. I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, an "Authorized Discloser") to provide Life Settlement Providers, LLC., and/or its authorized representatives (collectively, the "Authorized Recipient"), my life insurer, with any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, AIDS/HIV, drugs or alcohol abuse, of or related to the insured.

2. This authorization allows for the disclosure, inspection, and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatments or hospitalization, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control. This authorization shall apply to any and all of the insured's health and medical records and information whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

3. Release of Policy Information. I understand that the information authorized for release may also include life insurance policy information, including but not limited to, applications, forms, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my insurance company to furnish Life Settlement Providers, LLC. with any information herein described above.

4. I understand that settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transactions or in order to sell a life settlement contract (each an "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose for pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this authorization. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy of this facsimile of this authorization shall be valid as the original.

5. I agree that this authorization shall remain valid for the life of the undersigned (or the last to survive of the undersigned if more than one signatory) or until the policy lapses without the possibility of reinstatement, whichever is earlier, absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under.

6. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser 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 Discloser; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

7. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization: I understand that this authorization is voluntary and I am not required to sign. No Authorized Discloser 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 Discloser 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.

The following will be needed to obtain an offer:

Please use this checklist to ensure that you have enclosed all the documents necessary to process your application efficiently.

- _____ This application completed in its entirety.
- _____ Notice of Disclosure.
- _____ Photocopy of the insured's driver license.
- _____ Photocopy of the Life Insurance Policy.
- _____ Photocopy of medical records for the past five years. (*Optional)
- _____ In-force Illustrations solving for zero cash value in year 10. (*Optional)
- _____ If policyowner has ever been bankrupt, include a copy of the bankruptcy discharge.
- _____ If the policyowner has ever been divorced, include a copy of the divorce decree.

* These items are optional, but if included the response time will improve.

Mail all documents and copies to:

**Life Settlement Providers, LLC
Attn: New Business
6302A North Point Road
Baltimore, MD 21219-1015
Toll Free:866.509.5534**

Remarks (If more space is required, please attach additional pages.)

I hereby certify that I personally solicited and secured this application, to the best of my knowledge, information, and belief there is nothing for or against the risk which is not fully set forth in these papers.

Date	Producer Actually Soliciting Application	Agency
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Producer Code #

PARAMETERS

Policies must be past the contestability period.
Policies must be currently in force.
Policies must be in excess of \$100,000 in death benefit.

TYPES OF POLICIES

Term Insurance

Universal Life

Whole Life

Survivorship

2nd to Die

A- or better by A.M. Best

REQUIRED INFORMATION

- Application
- Copy of Driver License
- Insurance Release
- Medical Release
- Copy of Policy
- Illustration

The Concern About Privacy

Privacy is an important issue. We are all concerned about protecting the details of our personal lives from access by strangers. This concern is heightened when the information involves our financial situation.

The heightened anxiety about privacy can be attributed, in many respects, to the proliferation of e-commerce; the deregulation of the financial services business; and the creation of large, multi-purpose financial institutions.

Keeping Your Information Confidential

We seek to keep all personal information given in the strictest confidence. We do not sell or rent information to unaffiliated third parties and, in the future, would not do so without your prior approval. We limit access to your information by employees and other representatives to those individuals who have a business reason for knowing it. We maintain physical, electronic, and procedural safeguards to protect this information.

Personally Identifiable Information We May Collect

The types of non-public information we collect include:

- Information we receive from you on applications or other forms, such as your address and phone number, social security number, insurance policy information, medical records.
- Information we receive from third parties including attending physicians, hospital records, insurance company records.
- Information provided by visitors to our website using online forms.

Collection Sources

We collect non-public personal information about you from the following sources:

- Information we receive from you on applications or other forms.
- Information about your transactions with us, our affiliates, or others.
- Information we receive from a physician, hospital, insurance company.

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law.

How We May Use the Information You Provide

Life Settlement Providers, LLC uses information to provide requested viatical and life settlement services and does not disclose non-public personal information about you to any company that is not affiliated with us, except as otherwise required or permitted by law. We limit the sharing of your non-public information; no action is necessary on your part to limit such sharing.

If you have any questions, please write to us at:

Life Settlement Providers, LLC
6302A North Point Road
Baltimore, MD 21219-1015
866-509-5534