



## APPLICATION PACKAGE

This application is for:  a **viatical settlement**     a **life settlement**  
(Please check only one.)

**Life settlements** enable people who no longer want or need their life insurance – and *who do not have a catastrophic or life-threatening illness or condition* – to receive an advance cash payment for their policy.

**Viatical settlements** provide that same option to people who do have a catastrophic or life-threatening illness or condition.

FORM: KY APP 002

Revised 081106

Building 11, Piedmont Center ■ 3495 Piedmont Road NE, Suite 910 ■ Atlanta, Georgia 30305  
404-233-8275 ■ 888-874-2402 ■ Fax: 404-233-9394

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*A few simple forms help us gather the information  
we need to assist you*

- **Document Checklist.** This helps ensure we have all the information we need to serve you to the best of our abilities. We will not be able to proceed with your file until we have all of the listed items.
- **Application.** If you have more than one life insurance policy, please complete the areas on the application for additional policies. If you have more than one medical provider from whom we'll need to collect information, please provide complete information for each physician or other information source.
- **Representations, acknowledgements and warranties.** Be sure to read thoroughly and sign the application, including this section.
- **Disclosure Notice.** Information that is important to know if you are considering a viatical or life settlement.
- **Authorization to Release Medical Information.** We need your "okay" to access your medical records and other pertinent information about your current and ongoing health status.
- **Authorization for Disclosure of Protected Health Information.** In keeping with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations"), we need your HIPAA-compliant approval on this additional form (also used to access your medical records and other pertinent information).
- **Authorization to Release Life Insurance Policy Information.** again, your permission is required to gather information about your life insurance policy(ies).

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## DOCUMENT CHECKLIST

**To ensure that we can process your case quickly and provide you with the most complete feedback possible**, please include all of the requested information and materials. Please check off the documents requested as you gather them and sign below when you have assembled a complete package. Call us toll-free at 1-888-874-2402 if you have any questions.

Application Questionnaire (Pages 7-12)  
(Please note that there are two questionnaires – one for insured and one for owner.)

Representations, acknowledgements and warranties (Page 11-12)  
 **signed by insured**  **signed by owner** (if different from insured)

Disclosure Notice (Pages 13-14)  **signed by insured**  **signed by owner**  
(if different from insured)

Medical Release (Page 15)  **signed by insured**  **notarized**

HIPAA Disclosure (Pages 17-18)  **signed by insured**  **notarized**

Life Insurance Policy Information Releases (there are two of these) (Pages 21-23)  
 **signed by owner**  **notarized**

Photocopy of your Driver's License or other government-issued photo ID.  
(If the policy OWNER and the INSURED are different, we need copies of identification for BOTH persons.)

Photocopy of your Social Security card (or additional photo ID.)  
(If the policy OWNER and the INSURED are different, we need copies of identification for BOTH persons.)

Copy of your individual insurance policy (*including the policy application*)

Copy of your bankruptcy discharge papers  
(if you have gone through a bankruptcy within the past 10 years)

Copy of your divorce decree and any documentation of settlement and/or custody arrangements  
(if you have ever gone through a divorce)

### **If you have Group Life Insurance through your Employer or Membership Association:**

A copy of your employee/member handbook/certificate explaining your group life benefits \*

A copy of your group life insurance employee/member enrollment application \*

A copy of your personal insurance certificate indicating the face amount of your coverage \*

If on Disability Waiver of Premium, a copy of approval letter from the insurance company \*

A copy of your latest pay statement indicating premiums withheld, if you pay premiums on your employer-sponsored insurance \*

\* If you do not have one or more of these items, please call us to discuss alternatives.

**Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

*Continued, please see next page.*



## DOCUMENT CHECKLIST, Continued

**If the owner or beneficiary is a trust, we need:**

A copy of the trust document(s) and the Tax ID #. The Tax ID # is \_\_\_\_\_.

The trustee(s) to sign the Life Insurance Policy Information Release form(s).

**If owner or beneficiary is a corporation, we need:**

Complete name and address of corporation.

Corporate resolution showing current authorized officers.

Two corporate officers to sign the Life Insurance Policy Information Release form(s).

I certify that I have provided all of the above documents as indicated by my mark and that they are included within this packet I am returning to Habersham Funding LLC.

Signed \_\_\_\_\_ Date \_\_\_\_\_



# APPLICATION QUESTIONNAIRE

**Information about the INSURED.** Please see page 10 if you are the OWNER of the policy. Check here if the insured also is the owner of the policy:

**The insured and the policy owner are the same person.**

Full Legal Name: \_\_\_\_\_

Please list any aliases or nicknames: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  Height \_\_\_\_ Weight \_\_\_\_

Social Security # \_\_\_\_\_

Driver's License # & State: \_\_\_\_\_ Please provide photocopy of your license.

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**May we leave a message?** (Please circle at least one): Hm: \_\_\_\_\_ (yes/no)

e-mail: \_\_\_\_\_ Wk: \_\_\_\_\_ (yes/no)

Other #/cell \_\_\_\_\_ (yes/no) Fax: \_\_\_\_\_ (yes/no)

Have you ever been or are you now a party to a:

Bankruptcy? Yes \_\_\_ No \_\_\_ Civil suit? Yes \_\_\_ No \_\_\_ Divorce decree? Yes \_\_\_ No \_\_\_

Judgments? Yes \_\_\_ No \_\_\_ Tax lien? Yes \_\_\_ No \_\_\_ Creditor liens? Yes \_\_\_ No \_\_\_

## EMPLOYMENT INFORMATION

Are you currently working? Yes \_\_\_ No \_\_\_ Are you retired? Yes \_\_\_ No \_\_\_

What is/was your occupation? \_\_\_\_\_

Are you receiving disability benefits? Yes \_\_\_ No \_\_\_ What kind? \_\_\_\_\_

Are you receiving (circle which applies): SSI Medicaid Food Stamps None of these

## INSURANCE INFORMATION (please list additional policies on the following pages)

### 1st Policy:

Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Beneficiary(ies): \_\_\_\_\_

Premiums: \$ \_\_\_\_\_ per \_\_\_\_\_ (month, quarter, year, etc.)

Policy Type (circle one): **Group** **Group Conversion** **Individual**

**If your policy is a group policy, please complete the following:**

Employer Name: \_\_\_\_\_

Address & Phone: \_\_\_\_\_



APPLICATION QUESTIONNAIRE, Continued

Benefits Manager (for your employer): \_\_\_\_\_

May we contact this person in order to gather information about your policy? Yes \_\_\_ No \_\_\_

ADDITIONAL POLICIES:

2<sup>nd</sup> Policy:

Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Beneficiary(ies): \_\_\_\_\_

Premiums: \$ \_\_\_\_\_ per \_\_\_\_\_ (month, quarter, year, etc.)

Policy Type (circle one): **Group** **Group Conversion** **Individual**

3<sup>rd</sup> Policy:

Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Beneficiary(ies): \_\_\_\_\_

Premiums: \$ \_\_\_\_\_ per \_\_\_\_\_ (month, quarter, year, etc.)

Policy Type (circle one): **Group** **Group Conversion** **Individual**

Has an application for insurance on the insured's life/health ever been declined, rated or modified in any way (including this policy)? Yes \_\_\_ No \_\_\_ If yes, please describe the circumstances: \_\_\_\_\_

What is the total face value of life insurance on your life that is NOT being offered for sale here? \_\_\_\_\_

HEALTH INFORMATION

(please list additional physicians/medical providers on the following pages)

Please provide a brief description of your health condition (even if you consider yourself well/healthy):

\_\_\_\_\_  
\_\_\_\_\_

What is your primary medical condition? \_\_\_\_\_

When was your primary medical condition first diagnosed? \_\_\_\_\_

What are your secondary medical conditions or health concerns? \_\_\_\_\_

When were these diagnosed? \_\_\_\_\_

Current/Primary Physician: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



APPLICATION QUESTIONNAIRE, Continued

Second Physician: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

Third Physician: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco? If so, please describe:

Has the insured used (now or ever before) alcoholic beverages? Yes \_\_\_ No \_\_\_ If yes, please answer:

Frequency: Daily \_\_\_ Weekly \_\_\_ Monthly \_\_\_ Occasionally \_\_\_

Average amount consumed each time insured drinks: 1-2 drinks [ ] 2-4 drinks [ ] 5 or more drinks [ ]

Has the insured ever undergone alcohol or other substance abuse treatment? If yes, please describe:

FAMILY HEALTH HISTORY

Table with 4 columns: Family Member, Age if living?, Deceased?, and If deceased, please list cause and age at time of death. Rows include Father, Mother, Brother, and Sister.

Please use a separate sheet of paper to list additional siblings.

Please INITIAL all that apply:

- List of statements for initialing: I have never been married, I am married, I am divorced, I am widowed, I have no children, I have minor children, One or more of my minor children are my legal dependents, I have no minor children.



APPLICATION QUESTIONNAIRE, Continued

Information about the Life Insurance Policy OWNER. Please see page 7 if you are the INSURED. Check here if the owner is not an individual person (ie – a trust, corporation, etc.):

[ ] The owner is an entity or organization, not an individual.

Full Legal Name of Owner: \_\_\_\_\_

For trusts or corporations, please list the names of trustee(s) or 2 officers; please include their contact information below: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Male [ ] Female [ ]

Social Security # (or Tax ID #, for trust/corporation): \_\_\_\_\_

Driver's License # & State (if individual) : \_\_\_\_\_ Please provide photocopy.

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

May we leave a message? (Please circle at least one): Hm: \_\_\_\_\_ (yes/no)

e-mail: \_\_\_\_\_ Wk: \_\_\_\_\_ (yes/no)

Other #/cell \_\_\_\_\_ (yes/no) Fax: \_\_\_\_\_ (yes/no)

Have you ever been or are you now a party to a:

Bankruptcy? Yes \_\_\_ No \_\_\_ Civil suit? Yes \_\_\_ No \_\_\_ Divorce decree? Yes \_\_\_ No \_\_\_

Judgments? Yes \_\_\_ No \_\_\_ Tax lien? Yes \_\_\_ No \_\_\_ Creditor liens? Yes \_\_\_ No \_\_\_

EMPLOYMENT INFORMATION (if individual)

Are you currently working? Yes \_\_\_ No \_\_\_ Are you retired? Yes \_\_\_ No \_\_\_

What is/was your occupation? \_\_\_\_\_

Are you receiving disability benefits? Yes \_\_\_ No \_\_\_ What kind? \_\_\_\_\_

Are you receiving (circle which applies): SSI Medicaid Food Stamps None of these

Please INITIAL all that apply (if individual):

\_\_\_\_\_ I have never been married.

\_\_\_\_\_ I am married. My spouse's name is \_\_\_\_\_.

\_\_\_\_\_ I am divorced. Attached is a complete copy of the dissolution of marriage, including any or all property and/or settlement orders.

\_\_\_\_\_ I am widowed.

\_\_\_\_\_ I have no children.

\_\_\_\_\_ I have minor children.

\_\_\_\_\_ One or more of my minor children are my legal dependents.

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



REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

Insured and owner hereby represent and agree that: all the information provided to Habersham Funding LLC is correct, complete and not misleading. Insured and owner will immediately notify Habersham Funding of changes in any of the information contained herein or provided elsewhere to Habersham Funding.

Habersham Funding is authorized, but not obligated, to provide policy(ies) along with insured and/or owner's medical, financial and/or other personal information, to the organization(s) of its choice.

Habersham Funding purchases policies for its own account and for the accounts of other parties. Habersham Funding has no duties, fiduciary or otherwise, to Applicant. No principal/agent relationship is created hereby.

Insured and owner hereby represent, warrant, acknowledge and agree that: the subject life insurance policy(ies) was legally obtained, and to the best of insured's and owner's knowledge, all of the information contained in the insurance application(s) for the subject life insurance policy(ies) is true, correct, complete and not misleading.

**If insured or owner knowingly present false or fraudulent information in an insurance, viatical or life settlement application, then the insured and/or owner are guilty of a crime and may be subject to fines and confinement in prison. Insured and owner understand that in some states, Habersham Funding is required by law to report suspected insurance, viatical or life settlement fraud. Insured and owner understand, acknowledge and agree that, Habersham Funding will report all suspected insurance, viatical or life settlement fraud it discovers related to the subject life insurance policy(ies).**

By the submission of this application to Habersham Funding, insured and owner hereby knowingly waive any and all claims they may have against Habersham Funding arising from Habersham Funding or any person to whom Habersham Funding presents said application reporting insured and owner for suspected insurance, viatical or life settlement fraud and agree to hold Habersham Funding harmless for any such report to law enforcement, regulatory or insurance company officials for suspected insurance, viatical or life settlement fraud whether or not it is ultimately determined that any such fraud was committed.

As insured and owner, I have signed the accompanying medical and policy information releases, and I will authorize any person or entity to release any information or documents required to verify my submissions or otherwise to complete any settlement transaction. Further, I am age eighteen or above and am mentally competent.

**I acknowledge that I have read and understand the contents of the Representations, Acknowledgements and Warranties.**

\_\_\_\_\_  
Signature of insured

\_\_\_\_\_  
Signature of policy owner, if other than insured

\_\_\_\_\_  
Printed name of insured

\_\_\_\_\_  
Printed name of owner

\_\_\_\_\_  
Date signed by insured

\_\_\_\_\_  
Date signed by owner

**Must Be Notarized**

**Must Be Notarized**

State of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
My Commission Expires  
FORM: KY APP 002

\_\_\_\_\_  
My Commission Expires

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REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

*continued*

\_\_\_\_\_  
Signature of **spouse of owner**, if the owner or spouse  
resides in a community property state (AZ, CA, ID, LA,  
NM, NV, PR, TX, WA and WI)

\_\_\_\_\_  
Printed name of spouse of owner

**Must Be Notarized**

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
My Commission Expires



**DISCLOSURE NOTICE:  
A NOTICE TO APPLICANTS  
KENTUCKY FORM VS007**

FORM: KY APP 002

Revised 081106

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**THE KENTUCKY VIATICAL SETTLEMENT DISCLOSURE FORM  
NOTICE REGARDING VIATICAL SETTLEMENT CONTRACTS**

**NOTE:** SELLING YOUR LIFE INSURANCE POLICY could be a good decision or a bad one. To make sure you understand the facts you should:

- 1) Know that there are possible alternatives to viatical settlement contracts for persons with catastrophic or life-threatening illnesses, including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy.
- 2) The viatical settlement could be subject to the claims of creditors.
- 3) All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between you and the viatical settlement provider. If asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew this permission to share information every two years.
- 4) Know that a viatical settlement provider shall not discriminate in making viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status.
- 5) Know that a viatical settlement provider shall not discriminate between a viator with a dependent and a viator with no dependent.
- 6) Some or all of the proceeds of the viatical settlement may be taxable, and that assistance should be sought from a personal tax advisor.
- 7) Receipt of a viatical settlement may adversely affect your eligibility for Medicaid or other government benefits or entitlements, and that advice should be obtained from the appropriate agency.
- 8) Viaticating a joint policy or policy with family riders or coverage of any life other than yours may cause a loss of coverage on the other lives and that you should consult with an insurance advisor.
- 9) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by you. Assistance should be sought from a financial adviser.
- 10) Know that the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate shall be disclosed to you. Also, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the viatical settlement provider's interest in those benefits shall also be disclosed to you. Be sure that you are aware of these additional riders and that they may provide more value to your policy.

11) You are entitled to know the name, address, and telephone number of the independent third-party trustee. You may inspect and receive copies of the relevant trust, or escrow agreements, or other documents.

**Yes, I am requesting this information.**

**No, I do not want this information at the present time, however, I may request at a later date.**

12) You have the right to receive the amount and method of calculation of any fee, commission, or compensation to be paid the viatical settlement broker.

**Yes, I am requesting this information.**

**No, I do not want this information at the present time, however, I may request at a later date.**

13) You have the right to know the affiliation, if any between the viatical settlement provider and the issuer of the insurance policy to be viaticated.

**Yes, I am requesting this information.**

**No, I do not want this information at the present time, however, I may request at a later date.**

14) You should know that you have the right to rescind a viatical settlement contract within thirty (30) days of the date it is executed by all parties or within fifteen (15) days of the receipt of the viatical settlement proceeds by the viator, whichever is less, that the contract is rescinded if the insured dies within the rescission period.

15) The viatical settlement provider shall deposit the proceeds due you and any commissions due the viatical settlement broker with an independent third-party trustee within three (3) days of receipt of the contract signed by yourself. The independent third-party trustee shall mail proof of deposit within three (3) days of deposit, and that the funds will be available to you within two (2) business days of notification from the insurer of the effect of the transfer of ownership.

16) The provider is required to notify you within twenty (20) days of the change of ownership or beneficiary.

17) Know that within three (3) days of execution of the viatical settlement agreement, the viatical settlement provider shall mail to you copies of the following:

a) The executed viatical settlement contract

b) The application for the Viatical settlement contract

c) The statement from the licensed attending physician that the viator is of sound mind and not under undue influence or constraint

d) If the viator and insured are the same person, any medical report on the insured obtained by the provider

**I hereby declare that I have read and understand the 17 disclosure statements listed above.**

\_\_\_\_\_  
Printed Name of Viator

\_\_\_\_\_  
Signature of Viator

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name of Viator

\_\_\_\_\_  
Signature of Viator

\_\_\_\_\_  
Date Signed

**Caution: Please be sure that you have completed questions 11, 12 and 13.**

\_\_\_\_\_  
Printed Name of Viatical Settlement Provider

\_\_\_\_\_  
Signature of Viatical Settlement Provider

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name of Viatical Settlement Broker (if any)

\_\_\_\_\_  
Signature of Viatical Settlement Broker (if any)

\_\_\_\_\_  
Date Signed



# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Authorized Parties: Any physician, hospital or medical related facility, insurance company, the Medical Information Bureau, life expectancy estimating company, Insurer, or other institution.

Authorized Information: any records, charts, X-rays, laboratory work or similar information regarding my health, including, but not limited to, information relating to AIDS, ARC, HIV, heart disease, cancer, alcohol and/or drug abuse, mental illness, communicable diseases and any life threatening or terminal conditions.

The Authorized Parties are directed to release the Authorized Information to Habersham Funding, LLC, their representatives or their successors or assigns.

If the Policy has been in effect for less than five years, the Authorized Information shall be released to the Insurer.

I understand that information obtained will be used to evaluate the Policy for sale to Habersham Funding, LLC or its successors or assigns.

I understand that information obtained will be used to evaluate my life expectancy.

I understand that this information will be used to establish my life expectancy now and in the future.

This authorization is valid for the maximum period allowed by law. A photocopy or facsimile is as valid as the original.

This Authorization to Release Medical Information will be used to monitor my on-going health status.

This is durable document meant to survive regardless of my future mental condition and is meant to remain in force following my death.

I acknowledge and agree to all of the above.

\_\_\_\_\_  
Signature of **insured**

\_\_\_\_\_  
Printed name of insured

\_\_\_\_\_  
Date signed by insured

**Must Be Notarized**

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.



Signature of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
My Commission Expires

Revised 081106

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliant)

The undersigned insured(s) (hereafter referred to as "I"), authorize the disclosure of my protected health information (PHI) as follows:

- 1. Classes of persons authorized to disclose my protected health information: I authorize each physician, doctor, physician practice group, nurse, hospital, and any other health care provider (each, an "Authorized Discloser") to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this authorization.
2. Person authorized to receive my protected health information: I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to Habersham Funding, LLC (Habersham Funding), [including its officers, employees, agents, independent contractors and authorized representatives (including but not limited to financing entities and life expectancy evaluation companies)] and to any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (collectively, the "Authorized Recipient"). 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.
3. Description of protected health information authorized for disclosure and the purpose for such disclosure: This authorization shall apply to any and all of my health and medical records information, whether or not personally 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 purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible purchase by the Authorized Recipient (and/or its funding entities) of any and all life insurance policies under which my life is insured and (2) to verify, track and monitor my health medical status and condition in connection with any and all life insurance policies under which my life is insured that the Authorized Recipient purchases.
4. Expiration of authorization: This authorization shall remain valid until, and shall expire on, the date of my death, or for the maximum extent allowed by law from the date thereof.

Initial \_\_\_\_\_ Date \_\_\_\_\_

Continued, please see next page.



AUTHORIZATION OF RELEASE OF PHI
continued

- 5. 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 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 (a) the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation or if this authorization was obtained or (b), 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, my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and my PHI that is disclosed to the 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 as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Any person who knowingly presents false information in a life settlement application, contract or agreement is guilty of a crime and may be subject to fines and confinement in prison.

Signature of insured

Printed name of insured

Must Be Notarized

State of

County of

Subscribed, sworn to and acknowledged before me this day of, 20.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires



## A NOTE ABOUT YOUR AUTHORIZATION(S) TO RELEASE LIFE INSURANCE POLICY INFORMATION

- Policy OWNER must **sign and have notarized** both attached copies of the Authorization to Release Life Insurance Policy Information.

This page intentionally left blank.



AUTHORIZATION TO RELEASE LIFE INSURANCE POLICY INFORMATION

I hereby authorize \_\_\_\_\_, the issuer of Policy Number \_\_\_\_\_ and/or Certificate number \_\_\_\_\_ owned by \_\_\_\_\_ and insuring the life of \_\_\_\_\_

to release to Habersham Funding LLC, a copy of the application(s), policy, forms, riders or amendments of my policy. Further, I respectfully request and authorize that you send Habersham Funding LLC, any information they need pertaining to my policy, employment or health, including information that you would normally restrict to sending me, my physician, or the policy owner/insured.

Please treat any and all inquiries and requests made by Habersham Funding LLC, and its agents as if made by me directly. I agree that this authorization is valid for two years or for the maximum extent allowed by law from the date thereof, and that a photocopy or facsimile is as valid as an original. This release will be used to gather policy information to complete the evaluation, transfer, sale and/or resale of the policy.

Signature of policy owner

Printed name of owner

Date signed by owner

Must Be Notarized

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires

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## AUTHORIZATION TO RELEASE LIFE INSURANCE POLICY INFORMATION

I hereby authorize \_\_\_\_\_, the issuer of Policy Number  
\_\_\_\_\_ and/or Certificate number \_\_\_\_\_

owned by \_\_\_\_\_ and insuring the life of  
\_\_\_\_\_, to release to Habersham Funding LLC, a copy of the application(s),  
policy, forms, riders or amendments of my policy. Further, I respectfully request and authorize that you send  
Habersham Funding LLC, any information they need pertaining to my policy, employment or health,  
including information that you would normally restrict to sending me, my physician, or the policy  
owner/insured.

Please treat any and all inquiries and requests made by Habersham Funding LLC, and its agents **as if  
made by me directly**. I agree that this authorization is valid for two years or for the maximum extent  
allowed by law from the date thereof, and that a photocopy or facsimile is as valid as an original. This release  
will be used to gather policy information to complete the evaluation, transfer, sale and/or resale of the policy.

\_\_\_\_\_  
Signature of policy **owner**

\_\_\_\_\_  
Printed name of owner

\_\_\_\_\_  
Date signed by owner

**Must Be Notarized**

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
My Commission Expires

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FORM: KY APP 002

Revised 081106

Building 11, Piedmont Center ■ 3495 Piedmont Road NE, Suite 910 ■ Atlanta, Georgia 30305  
404-233-8275 ■ 888-874-2402 ■ Fax: 404-233-9394